ASSESSMENT OF ATTITUDE ON RISK FACTORS ASSOCIATED WITH COMPLIANCE AND NONCOMPLIANCE OF NEUROLEPTIC TREATMENT AMONG PATIENTS WITH SCHIZOPHRENIA

DISSERTATION SUBMITTED TO

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ABSTRACT

Health is a state of complete harmony of the body, mind and spirit. When one is free from physical disabilities and mental distractions, the gate of the soul open.

Non-adherence to prescribed antipsychotic medications places patients with schizophrenia at a greatly increased risk of illness exacerbation and rehospitalization. The use of antipsychotic medication in the treatment of schizophrenia is well established and there is overwhelming evidence from clinical trials to demonstrate the benefits of these drugs for patients. Poor adherence to medication regimens is common, contributing to substantial worsening of disease, death, and increased health care costs. Practitioners should always look for poor adherence and can enhance adherence by emphasizing the value of a patient's regimen, making the regimen simple, and customizing the regimen to the patient's lifestyle. Asking patients non judgmentally about medication-taking behavior is a practical strategy for identifying poor adherence.

Patients who have difficulty maintaining adequate adherence need more intensive strategies than do patients who have less difficulty with adherence, a more for giving medication regimen, or both. Innovative methods of managing chronic diseases have had some success in improving adherence when a regimen has been difficult to follow. New technologies such as reminders through cell phones and personal digital assistants and pillboxes with paging systems may be needed to help patients who have the most difficulty meeting the goals of a regimen.

The monthly relapse rates are estimated to be 3.5 % per month for patients on maintenance neuroleptics and 11% per month for patients who have discontinued their medication. Post discharge noncompliance rates in community settings are estimated to be 7.6 % per month. These estimates were entered into a survival analysis model to determine the real world relapse rate. The utility of neuroleptics are substantial. Being able to give each patient the appropriate dosage of the right treatment should enhance not only its immediate efficacy, but also compliance and therefore long term efficacy.

This study aims to assess the attitudes and risk factors associated with compliance and noncompliance among patients with Schizophrenia. The objective of the study was to assess the attitude and the risk factors associated with compliance and non compliance of neuroleptic treatment. A descriptive research design was adopted for this study. The study was conducted in Raju Hospital at Chennai. Out patients and in patients with Schizophrenia who fulfilled the inclusive criteria were assessed using modified standardized tools which consists reasons of medication influences {ROMI} scale, Drug attitude inventory scale. Ethical aspects were considered throughout the study.

Analysis revealed that the percentage level of risk factor among compliance and non-compliance client.47(94.0%) client have mild influence and 3(6%) of clients have moderate influence irrespective of compliance and non compliance,AS and 18% of clients have unfavorable attitude, 82% of client have moderately favorable attitude.

The psychiatric nurse, as a nurse educator should aim at providing information to patients about both their illness and medication with the goal of increasing understanding and promoting compliance.

CHAPTER – I

INTRODUCTION

The non-compliance with maintenance neuroleptic treatment is a major barrier to the effective treatment of Schizophrenic disorders and also delivery of health care. The medication compliance in patients with Schizophrenia had been predicted by the patient's subjective response to treatment and attitudes towards antipsychotics. In this study, Attitude towards antipsychotic medication is significantly affected by the factors such as financial obstacles, substance abuse, negative relations with therapists, denial of illness etc.

Estimating compliance rates in people with schizophrenia has proved difficult for two reasons. Firstly, there is no agreed definition of compliance - definitions vary from complete cessation or verbal refusal to any significant deviation from prescription, including dosage errors or failure to attend appointments. Secondly, there is no valid way of measuring compliance. Rates of compliance have been measured using a number of different methods.

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Problems with non-compliance appear in all areas of medicine which closely related with treatment outcome. Factors associated with non-compliance can be identified in the patient, his network, the illness, the physician, the treatment setting and the medication itself (Blackwell, 1976). In schizophrenia, the patients are often incapable in recognizing their symptoms and seeking medical help. On the other hand, many symptoms of schizophrenia may result in distorted views about the purpose of both medication and other forms of psychiatric treatment.

Problems with compliance are common in all areas of medicine (Blackwell, 1976). It has been defined as the extent to which a person's behavior is in line with the medical advice given (Sackett & Haynes, 1976). Compliance is a multi- factorial phenomenon representing the patient's contribution to the treatment of illness. It is a complex phenomenon representing a patient's contribution to the management of illness (Sackett & Haynes, 1976; Babiker, 1986). It comprehends a wide variety of behaviours: failure to

enter a treatment programme, premature termination of therapy and incomplete implementation of instructions, like drug prescriptions.

Studies evaluating compliance or adherence issues in psychiatry have focused on drug treatment, non-attendance in outpatient treatment, rehabilitation programmes, and self- discharge from hospital against medical advice. Rates of non-compliance in psychotic disorders have been reported to vary between 11 to 18% (Johnson, 1984; Kane, 1985; Ayuso-Gutierrez & del Rio Vega, 1997). The contributing factors of compliance in psychotic disorders can be divided in medication-related, patient-related and environmental components (Fenton, Blyler & Heinssen, 1997; Kampman & Lehtinen, 1999). Most of the studies deal with schizophrenia and related disorders, and a few with unselected groups of psychotic patients.

In general, psychiatric disorders may have a negative stigma among people, and negative attitudes towards psychiatric drugs are common both in patients and their relatives. In previous studies, the medication related factors of compliance in psychoses have been explored comprehensively, whereas the patient-related and other factors, such as the doctor-patient relationship, psychosocial treatment programmes or the accuracy of diagnostics received less attention.

BACKGROUND OF THE STUDY

Schizophrenia has long been recognized as the most severe and disabling of psychiatric illness. It is not just the clinical picture but the overall decline in the patients functioning that is relevant. Adherence to medication regimens has been monitored since the time of Hippocrates, when the effects of various portions were recorded with notations of whether the patient had taken them or not. Even today, patients' self-reports can simply and effectively measure adherence.

Adherence to (or compliance with) a medication regimen is generally defined as the extent to which patients take medications as prescribed by their health care providers. The word "adherence" is preferred by many health care providers, because "compliance" suggests that the patient is passively following the doctor's orders and that the treatment plan is not based on a therapeutic alliance or contract established between the patient and

the physician. Both the terms are imperfect and uninformative descriptions of medication-taking behavior. Unfortunately, applying these terms to patients who do not consume every pill at the desired time can stigmatize these patients in their future relationships with health care providers.

The language used to describe how patients take their medications needs to be reassessed, but these terms are still commonly used. Regardless of which word is preferred, it is clear that the full benefit of many effective medications that are available will be achieved only if patients follow prescribed treatment regimens reasonably , closely and intervene effectively in Schizophrenia.

There is no question that adherence to medication is essential to maximizing outcomes for individual with Schizophrenia. Compliance rates may be overestimated in the medical literature, as compliance is often high in the setting of a formal clinical trial but drops off in a real world setting While adherence is poor across a wide variety of physical and psychiatric conditions, the consequences of poor medication adherence can be devastating in Schizophrenia, where the personal and societal costs of relapse are very high. Although we continue to develop new antipsychotic and adjunctive treatments with broader efficacy and improved side effects profile, levels of adherence remain alarmingly low. Thus we think the patients with higher rates of relapse.

For decades, researchers have worked to explain the causes of poor adherence and to develop interventions. Unfortunately there has been remarkably little agreement regarding the definition of adherence or how it is best measured. Medication adherence is often defined as' the extent to which a person's behavior coincides with medical advice. However, different operational definitions and assessment methods identify different subgroups of patients. An agreed upon set of definitions and a better understanding of the measurement problems and how to address them are necessary, if we are going to unravel the complex nature of adherence.

Hospitalization may benefit from adding depot antipsychotics to oral antipsychotic regimen. A United States of America nationwide survey of 1,010 adults in 2001 found that 22% have chosen not to fill prescriptions because of the price, which is similar to the patients among 20% -30%.

SIGNIFICANCE AND NEED FOR THE STUDY

Medication compliance is one of the most difficult challenges in the management of schizophrenia in India. Several studies were conducted to find out the significant predictors of medication noncompliance. In 2005 it is estimated that the rate of non-compliance is about 50% during first year and 75% during second year, after the patients are discharged from inpatient care unit. Medication noncompliance is one of the main obstacles to control relapse in schizophrenia. It significantly increases the rate of relapse, length of hospitalization, and the risk for hospitalization in the future. The overall compliance rates for antipsychotic medication were lower than that of antidepressants and other drugs.

Majority of these studies are done in developed countries. Very few literatures are available from India and other developing countries regarding the attitudes and reasons of medication compliance. The current study has tried to assess the attitudes and reasons for compliance as well as noncompliance among patients with schizophrenia. It can provide basis for planning effective interventional strategies to the mental health professionals for improving compliance of the patient in the future.

Poor adherence to medication treatment can have devastating consequences for patients with serious mental illness. The literature review and recommendations in a article concerning assessment of adherence problems in patients with serious and persistent mental illness, published in 2009.The expert consensus survey contained 39 questions that asked about defining non adherence, extent of adherence problems in schizophrenia and bipolar disorder, risk factors for non adherence, assessment methods, and interventions for specific types of adherence problems. The survey was completed by 48 experts to whom it was sent. When evaluating adherence, the experts considered it important to assess both behavior and attitude, although they considered actual behavior is most important.

They also noted the importance of distinguishing patients who are not willing to take medication from those who are willing but not able to take their medication as prescribed due to forgetfulness, misunderstanding of instructions and financial or environ mental problems. Although self and physician report are most commonly used to clinically assess adherence, they are often inaccurate and may underestimate no adherence.

To assess baseline predictors and consequences of antipsychotic adherence during the long term treatment of schizophrenia outpatients, data were taken from the 3-year prospective and observational. European Schizophrenia Outpatients Health Outcomes [SOHO] study, in which outpatients starting or changing antipsychotics were assessed every 6 month. Physician rated adherence was dichotomized as adherence/non adherence. Regression models tested for predictors of adherence during follow up, and associations between adherence and outcome measures among 6731 patients were analysed, the findings are 71.2% were adherent and 28.8% were non adherent over 3 years.

The strongest predictor of adherence was a month before baseline assessment. Other baseline predictors of adherence included initial treatment for schizophrenia and greater social activities. Baseline predictors of non-adherence were alcohol dependence and substance abuse. On adherence was significantly associated with an increased risk of relapse, hospitalization and suicide attempts.

In India a study (1999) shows that individual with schizophrenia who have discontinued antipsychotics in the previous 12 months, the findings were50% improved but require extensive support network,10% hospitalized and unimproved, 25% partially recovered,10% dead.

Discontinuation of the initiated treatment was used as criterion for effectiveness and patient's drug attitude was shown to be predictive for non-adherence or discontinuation of long term treatment in schizophrenia. As the noncompliance leads to relapse in schizophrenia, the investigator felt that it is essential to assess the attitude and reasons for noncompliance of neuroleptic treatment and it will be very useful to the health professionals.

TITLE

Assessment of attitude on risk factors associated with compliance and non-compliance of neuroleptic treatment among patients with schizophrenia.

STATEMENT OF THE PROBLEM

A study to assess the attitude on risk factors associated with compliance and non-compliance of neuroleptic treatment among patients with schizophrenia in Raju Hospital at Chennai.

OBJECTIVES

1. To assess the attitude on compliance and non compliance of neuroleptic treatment among patients with schizophrenia.
2. To assess the risk factors on compliance and non-compliance of neuroleptic treatment among patients with schizophrenia.
3. To associate the level of risk factors on compliance and non-compliance of neuroleptic treatment with the demographic variables.
4. To associate the level of attitude on compliance and non-compliance of neuroleptic treatment with the demographic variables.

VARIABLES

Research Variable

Independent variable

Attitude on compliance and non-compliance with neuroleptic treatment.

Dependent variable

Risk factors on compliance and non-compliance with neuroleptic treatment.

Demographic Variables

Age, sex, marital status, family income, living situation, prescribed regimen and onset of illness.

ASSUMPTIONS

1. Non-compliance of the neuroleptic treatment has a strong influence on relapse of schizophrenic clients.
2. Relapse can have long term effects on outcome of schizophrenic clients

3. Health professional has an important role to play in guiding the family members regarding prevention of relapse.

OPERATIONAL DEFINITIONS

Attitude

Attitude is the hypothetical construct that represents an individual degree of behavior.

Risk factors

Risk factors are factors that increases a person's chances of developing disease or disorder

Compliance

The degree of consistency and accuracy with which a patient follows the prescribed regimen.

Non-compliance

Disregarding of a prescribed treatment plan

Neuroleptic treatment

Neuroleptic or an antipsychotic is a psychiatric medication primarily used to manage psychosis particularly used in schizophrenic disorder.

Relapse

The recurrence of a disease after apparent recovery

Patient with schizophrenia

The person who is diagnosed as having Schizophrenia by the Psychiatrist

DELIMITATION

This study is delimited to the schizophrenic clients who have relapse episode

PROJECTED OUTCOME

1. The assessment and identification of attitude regarding noncompliance of neuroleptic treatment will help the nurses to take meticulous actions in advance, which will prevent relapse in.
2. The findings would provide an insight regarding areas where the patients and family members would change the behavior regarding compliance and noncompliance of neuroleptic treatment.
3. And these findings can help to plan for many education programmers so for it can prevent the relapse in schizophrenic clients.

SUMMARY

This chapter contains background of the study, significance and need for the study, title, statement of the problem, objectives and variables of the study, assumptions, operational definitions, delimitations and projected outcome.

ORGANIZATION OF THE REPORT

The following chapter contains

Chapter – II - Review of literature and conceptual framework.

Chapter – III - Methodology.

Chapter – IV - Analysis and interpretation.

Chapter – V - Discussion.

Chapter – VI - Summary, implications, recommendations and limitations

This is followed by reference and appendices.

CHAPTER – II

REVIEW OF LITERATURE

The review of literature is based on extensive survey of journals, nursing books and international nursing journals. A review of literature relevant to the study was undertaken which helps the investigator to develop deep insight in to the problem and gain information what has been done in the past.

An extensive review of literature was done by the investigator to a broad foundation for the study and conceptual framework to proceed with the study under the following headings.

Section – A: Literature regarding non compliance of neuroleptic treatment.

Section – B: Literature regarding risk factors associated with non compliance of neuroleptic treatment.

Section – C: Literature regarding attitude on compliance of neuroleptic treatment.

SECTION–A: LITERATURE REGARDING NON-COMPLIANCE OF NEUROLEPTIC TREATMENT

Kennedy, et al., (2000) conducted a study which showed that there is also good evidence that the prophylactic use of antipsychotic medication prevents relapse.

Taylor, et al., (2000) conducted a study which showed that prescriptions for antipsychotics are often inappropriate, resulting in unwanted and unnecessary side-effects. Non-compliance suggests that the patient has not done what they were told by a mental health professional i.e. stopped taking medication.

Marder, et al., (1999) conducted a study which demonstrated that compliance with antipsychotic medication is generally poor and not taking medication is associated with a substantial increase in rehospitalizations and a poorer outcome in people with schizophrenic disorders.

Marley, et al., (1999) found that the modern mental health care is concerned and working with patients, consequently it has been proposed that 'concordance' should replace the use of the word 'compliance'. Concordance emphasizes patient rights, the need for information and the importance of two-way communication and decision-making. In contrast with a compliance, they suggested that patients have the right to make decisions (such as stopping medication) even if clinicians do not agree with the decision. The focus of this review is therefore to examine interventions that improve the taking of prescribed antipsychotic medication.

Repper & Perkins (1998) highlighted that the importance of language in mental health and suggested the use of words like compliance infer that patients are passive recipients of health care who should be obey the instructions from professionals.

Cramer & Rosenheck (1998) proposed an average non-compliance rate of approximately 42%, a finding that is similar to rates in other mental and physical disorders.

Kemp, et al., (1997) have proposed that the so called 'revolving door phenomena' can be almost exclusively attributed to repeated non-compliance. Kisling (1994) has argued that if patients were completely compliant with their medication, relapse rates would fall to about 15%. Currently 50% of patients relapse within a year of achieving remission. However, the poor compliance can be attributed solely to the patient's failure to do what clinicians have told them must be juxtaposed with evidence that professionals often do not carry out their own responsibilities regarding medication.

Thomas, et al., (1997) conducted a study which showed that neuroleptic efficacy accounted for 60% of the rehospitalization costs and neuroleptic noncompliance for roughly 40 percent. The economic burden due to loss of efficacy is relatively higher during the first post discharge year, whereas the burden from noncompliance is higher in the second year. Because loss of medication efficacy, medication noncompliance act synergistically on relapse and substantial inpatient cost savings can be realized by linking better pharmacologic treatments of schizophrenia with more effective strategies to manage medication noncompliance.

Kemp & David (1996) showed a significant relationship between insight and compliance. In schizophrenia, insight - defined as awareness of illness, an ability to recognize symptoms as part of an illness and acceptance of treatment - has also been associated with compliance. A number of studies have been examined the relationship between insight and compliance with generally consistent results, despite substantive differences in operational definitions of insight.

Churchill (1995) highlighted that the rates of compliance have been measured by using a number of different methods; however, none has proved satisfactory. These include physicians' assessment and patients' self-report, pill counts, and urine and blood assays. These methods of assessment are not always reliable. Patient self-report and physician assessment are inaccurate, both consistently overestimating compliance. Pill counts are more reliable, but it is impossible to tell whether the patient has actually ingested the medication. Urine testing for drug with a long half-life will tend to overestimate compliance. As most neuroleptics have a relatively long half-life, blood assay is likely to prove more reliable. However, the degree of compliance is impossible to determine and therefore blood assays can only be used as a criterion for current compliance.

McEovy, et al., (1989) conducted a study which proved that a number of interpersonal (such as the therapist's ability to listen and empathize with the patient) and relationship factors (liking and trusting the therapist, and the patient's level of involvement in treatment decisions including discussion of the patient's beliefs, concerns and expectations have been shown to correlate with compliance in patients with mental disorders.

Appelbaum & Gutheil (1980) who interviewed 40 patients who refused antipsychotic medication during a 3- month period. In that ,Psychotic psychopathology, especially paranoia, suspi- ciousness, grandiosity and delusional beliefs about medication, were highlighted as influencing compliance .

Quit-kin, et al., (1978) used clinician judgement to determine compliance and observed only 10% of patients were non-compliant with their medication over a 12-month period.

Van Putten et al. (1976) observed that grandiose delusions were more common in non- compliant patients. The more severe a patient's psychopathology, the worse in their compliance.

Renton, et al., (1963) examined this relationship in a study of 132 patients. They reported that the severity of patients' symptom at the time of discharge was significantly associated with future adherence.

Wolff & Colacino, (1961), using patient interviews over a 6-month period, reported that 73% of patients were non-compliant.

SECTION – B: LITERATURE REGARDING RISK FACTORS ASSOCIATED TO NON COMPLIANCE

Miner, et al., (1997) conducted a study which showed that substance abuse seems to be a strong predictor of non-compliance in psychosis, especially in men . More specifically, non-compliance has correlated more clearly with heavy than with slight alcohol and with the use of marijuana.

Laura D, (1992) suggested that non adherence to prescribed antipsychotic medications places patients with schizophrenia at a greatly increased risk of illness exacerbation and re hospitalization.

Stanly, et al., (1990) found that the factors most consistently associated with non-adherence included poor insight, negative attitude or subjective response toward medication, previous non-adherence, substance abuse, shorter illness duration, inadequate discharge planning or aftercare environment, and poorer therapeutic alliance. Findings regarding an association between adherence and medication type were inconclusive, although few studies explored this relationship. Other factors such as age, gender, ethnicity, marital status, education level, neurocognitive impairment, severity of psychotic symptoms, severity of medication side effects, higher antipsychotic dose, presence of mood symptoms, route of medication administration, and family involvement were not found to be consistent predictors of non-adherence.

Hemanth, et al., (1987) conducted a study and found the predominant reasons for discontinuation were: patient unconvinced about need for treatment (32%), poor efficacy (32%) and adverse events (7%). Only half of those experiencing poor efficacy were switched to another drug. Many patients appear to discontinue therapy for illogical reasons and this may be amenable to intervention.

Clara, (1987) found that Medication noncompliance was significantly associated with substance abuse. Subjects who abused substances, had no outpatient contact, and were noncompliant with medication had significantly greater symptom severity than other groups. Substance abuse is strongly associated with medication noncompliance among patients with schizophrenia. The combination of substance abuse, medication noncompliance, and lack of outpatient contact appears to define a particularly high-risk group.

Marland, et al.,(1987) conducted a study at Rutgers University in New Brunswick, New Jersey, USA, to identify predictors of noncompliance among schizophrenic clients. They highlighted patients with schizophrenia at high risk for medication noncompliance after acute hospitalization are characterized by a history of medication noncompliance. The recent substance use, difficulty recognizing their own symptoms, a weak alliance with inpatient staff, and family who refuse to become involved in inpatient treatment.

Wieden, et al., (1986) conducted a study which showed that contemporaneous side-effects had a weak but significant impact on compliance.

Yung ,et al.,(1985) conducted a study in Swiss, at Institute of Mental Health among 126 patients. In that (5.8%) were no longer receiving neuroleptic, the most common reasons for discontinuing treatment were actual side effects (61%) or the fear of side effects (25%). Overall, 16% of patients did not receive pharmacological therapy in accord with official Swiss guidelines.

Van Putten, (1974) demonstrated that an increased incidence of bradykinesia, dystonia and tremor, but not akathisia, was associated with patients who were reluctant to take medication. In this study, akathisia was not associated with non-compliance.

SECTION – C: LITERATURE REGARDING ATTITUDE ON COMPLIANCE OF NEUROLEPTIC TREATMENT

Walburn, et al., (2001) conducted a study which concluded that the patients showed more positive attitudes to depot medication compared with oral administration.

Val Enstein, et al., (2001) conducted a study which proved there is a need for quality improvement with prescribing guidelines of depot medications.

Smith, et al.,(1997) conducted a study which proved that the family members' awareness of the patient's illness is also connected to better compliance.

Fenton, et al.,(1997) conducted a study which showed negative attitudes towards antipsychotic medication predict non-compliance.

Smith, et al.,(1997) found that male patients had lower adherence compared with women in a skill training programme for chronic schizophrenia patients after relapse.

Razali and Yahya (1995), highlighted to consider the medication to be helpful in treating their illness and have a positive attitude toward medication. Conversely, noncompliant patients have no reason for taking medication because they are consider themselves to be ill, or they may see taking the medication as the wrong way to solve their problems.

Bebbington & Kuipers (1994) conducted a study which showed that the supportive family environment has been reported to have a positive effect on compliance.

Draine & Solomon, (1994) conducted a study which proved social activity has been related to more positive attitudes towards medication in outpatient care (but to poorer compliance with long-term rehabilitation patients.

Adams & Howe (1993) examined the factors that were likely to predict good compliance in 44 psychotic inpatients. The greater number of indirect benefits of medication (i.e. 'keeps me out of hospital' or 'it allows me to make new friends'), the more compliant patients had.

Awad, (1993) conducted a study which proved a negative change in the subjective state during medication has been associated with negative attitudes and impaired compliance.

Drake, et al., (1991) highlighted that living alone and poor housing increase the risk of medication non-compliance.

Wilms, et al., (1985) suggested that attitudes and illness concepts can be understood as the sum of opinions, interpretations, explanations, and predictions with regard to the state of an individual's health. These attitudes are largely independent of psychopathology and should not be confused with psychopathological symptoms such as "lack of insight into the illness.

Chan, (1984) suggested that there are a number of factors that influence patients' decisions about taking antipsychotic medication. Some factors are clearly more influential than others; insight, beliefs about treatment and side-effects appear to be particularly important.

Being clinically common and crucial in relation to outcome, problems with compliance arouse from multiple reasons. In psychotic disorders compliance involves the specific factors, such as side-effects of anti-psychotic medication, attitudes towards treatment and insight regarding symptoms, or disturbances in cognitive functioning. Most of the previous studies have focused on the weight of medication effects and side-effects. Similarly, attitudes towards medication, and the roles of psychopathology, insight and substance abuse are all well established as important factors regarding non-compliance.

PART – II

CONCEPTUAL FRAMEWORK

Conceptual framework based on Pender's Health Promotion Model.

This section deals with conceptual framework adopted for this study. A conceptual framework provides the investigator the guidelines to proceed in attaining the objectives of the study based on a theory. These are a schematic representation of the steps, activities and outcome of the study.

This model is concerned with the changing of behavior, developed and tested by Nola Pender, et al. The health promotion model is used to predict the likelihood of a person's engaging in health promoting behavior.

According to health promotion model, 7 cognitive /perceptual factors reflect on individual belief. These factors include individual belief, the importance of health, perceived threat to health, perceived control of health, perceived health status, perceived benefits of health promoting behavior and person's barriers to health promoting behavior.

Individual Belief

The schizophrenic clients who are on antipsychotics, many of them having negative attitude towards antipsychotic medication, so that there is no progression even after taking medication.

Perceived threat to health

Due to discontinuing the antipsychotics, the clients are prone to relapse

Perceived control of health

After perceiving the threat of relapse the client will modify his behavior into positive attitude

Importance of health

The schizophrenic clients strive to promote their health by being an adherent, so that they can decrease their relapse.

Perceived Health Status

The chronically ill schizophrenic clients experiencing relapse.

Perceived benefits of health promoting behavior

The schizophrenic clients accepting the importance of taking medication of antipsychotics and became a compliance so that there is no relapse.

Persons barrier to health promoting behavior

If schizophrenic clients not taking medication regularly because of negative attitude and risk factors, they will experience relapse.

The conceptual framework also includes modifying factors. The modifying factors are the demographic variables are age, sex, income, and marital status, onset of illness, prescribed medication, and living situation.

CHAPTER – III

METHODOLOGY

This chapter deals with research methodology which was undertaken for gathering and organizing data for investigation. It includes description of research approach, research design, variables under study, setting of the study, population, sample, sampling technique, sampling criteria, sample size, description of the tool, and pilot study.

Research methodology is a way to systematically solve a research problem. It is a science of studying how research is done scientifically. Methodology is a significant part of the research under which the researcher undertaken. The purpose of the present study is to assess the attitude on compliance and non-compliance of neuroleptic treatment among patients with schizophrenia that have at least one relapse episode.

RESEARCH APPROACH:

The research approach chosen for the study was descriptive research approach. It was designed to obtain information regarding attitude on risk factors associated to compliance and non compliance of neuroleptic treatment among schizophrenic clients.

RESEARCH DESIGN

The research design adopted for this study was non experimental descriptive research design.

RESEARCH VARIABLE

Independent Variable

Attitude on compliance and non-compliance with neuroleptic treatment.

Dependent Variable

Risk factors on compliance and non-compliance with neuroleptic treatment.

Demographic Variables

Age, sex, marital status, family income, living situation, prescribed regimen and onset of illness.

SETTING OF THE STUDY

Study setting is the general physical location in which data collection takes place (Polit & Beck 2004).

The study was conducted in an outpatient and inpatient psychiatric department of Raju Hospital, Chennai. It is located in the center of city. It is 30 bedded hospitals. There 50% of psychiatric patients are coming for neuroleptic treatment.

POPULATION

Target Population

The target population is comprised of all schizophrenic patients who have at least one relapse episode.

Accessible Population

It refers to the aggregate of cases which conform to the designed criteria and which is accessible to the researcher as the pool or objects. The accessible population comprised of all the schizophrenic patients who have at least one relapse episode and who are attending inpatient department and outpatient department during the study period in Raju Hospital, Chennai.

SAMPLE

The sample comprised of all the schizophrenic patients who had at least one relapse episode and who were attending inpatient department and outpatient department during the study period in Raju Hospital, Chennai.

SAMPLE SIZE

The sample size of the study comprised of 50 schizophrenic patients who had atleast one relapse episode.

SAMPLING TECHNIQUE

In this study Non- Probability Convenient Sampling technique was used to select subjects as they fulfilled the inclusion criteria.

CRITERIA FOR SAMPLE SELECTION

Inclusion Criteria

1. Schizophrenic patients who had at least one relapse episode.
2. Able to speak Tamil or English.

Exclusion Criteria

Schizophrenic patients who were non-willing to participate in the study.

METHOD OF DEVELOPING THE TOOL

The following steps were carried out in developing the questionnaire

1. Literature review
2. Expert's opinion

Literature Review

Literature from nursing books, journals, periodicals, published and unpublished research studies and news paper articles were reviewed and used to develop the tool.

Experts Opinion

The investigator had discussed with the experts and incorporated their valuable suggestions in developing the tool.

DESCRIPTION AND VALIDITY OF THE TOOL

The tool consists of two items. The content validity of the tools obtained by submitting the tool to the experts including 2 psychiatrists and 3 nursing experts for their opinion and suggestions. The changes were made according to expert's suggestions and opinion.

TOOL I:

Demographic variables which consists of 7 items. Verbal response was obtained from the psychiatric patients who have at least one relapse episode regarding age, sex, marital status, living situation, prescribed medication, income, onset of illness.

TOOL II:

Part – A

The attitude towards neuroleptic treatment was assessed using modified 30 item drug attitude inventory(DAI).It is a self-report questionnaire in which each item ticked' yes' is rated +1 and items ticked 'no's rated as 0.The positive scores and negative scores are calculated and the total score will be positive score minus negative score. Positive total score indicates positive attitude and negative total score indicates negative attitude towards neuroleptic treatment.

Part – B

The risk factors of neuroleptic treatment were assessed by using modified rating of medication influence (ROMI) scale. Subjective reasons of medication compliance, on compliance were assessed using 20 item (ROMI) scale

SCORING KEY

For assessing attitude modified(DAI) scale

30 item questions were used

Yes- +1 for positive attitude

No- 0 for negative attitude

Less than 50%- mild

50-75 %- moderate

Above 75 %-high

For assessing risk factors modified (ROMI) scale

20 items question were used

Reasons for compliance (7 open ended questions)

None- 1

Mild-2

Strong-3

The same scoring will be used for reasons for noncompliance (13 open ended questions)

PILOT STUDY

Pilot study was conducted at Aashiyana Hospital at Anna Nagar, Chennai, during the period of 22.04.2010 to 24.04.2010.The investigator selected 5 samples who fulfilled

inclusive criteria. The researcher collected the data through Interview schedule. On an average it took 30-40 minutes for each person to collect the data. There was no practical difficulties met by the investigator and the tools were considered to be reliable and appropriate. Hence the same procedure was decided to be followed in the main study.

The analysis taken for the above 5 patient resulted in reliability r=0.86 which helped in the further up gradation of the study.

PROCEDURE FOR DATA COLLECTION

Procedure for data collection for main study was conducted in Raju Hospital at T.Nagar, Chennai. The investigator collected totally 50 samples in which each day 5 patients were undergone this data collection procedure. Brief introduction was given regarding the purpose of research. The data was collected by using modified standardized tools and modified 3 point likert scale. Ethical aspects were conducted throughout the study.

Date	Number of samples
15.05.10 to 15.06.10	50

DATA ANALYSIS PROCEDURE

Both descriptive and inferential statistics were used.

Descriptive Statistics

Analysis of socio demographic data of schizophrenic patients were done in terms of frequency and percentage distribution.

Mean and standard deviation was used to complete degree of influence regarding attitude and risk factors of compliance and non compliance of neuroleptic treatment.

Inferential Statistics

Chi-square test was used to associate the attitude and risk factors with the demographic variable.

CHAPTER – IV

DATA ANALYSIS AND INTERPRETATION

This chapter deals with the analysis and interpretation of data collected from 50 samples to assess the level of attitude on compliance and non-compliance of neuroleptic treatment among patients with schizophrenia.

Data analysis is as evaluation of information and its pertinence to the study variable. Data analysis helps the researcher to organize, summaries, evaluate, interpret and communicate the numerical facts.

Descriptive and inferential statistics were used for the analysis of the data. As per the objectives of the study, the interpretation has been tabulated and organized as follows.

ORGANIZATION OF THE DATA

Section A : Socio demographic variable of the schizophrenic clients.

Section B : Assessment of level of risk factors of compliance and non-compliance of neuroleptic treatment.

Section C : Assessment of level of attitude on compliance and non-compliance of neuroleptic treatment.

Section D : Association of level of risk factors on compliance & non-compliance of neuroleptic treatment among schizophrenic clients with their demographic variables.

Section E : Association of level of attitude regarding compliance and non-compliance of neuroleptic treatment among schizophrenic clients with their demographic variables.

SECTION A

Table-1: Frequency and percentage distribution of demographic variables

n = 50

Age	**No.**	**%**
20-30 yrs	25	50
31-40yrs	15	30
41-50yrs	4	8
above 50 yrs	6	12
Sex		
Male	45	90
Female	5	10
Marital status		
Married	19	38
Single	31	62
Widow	0	0
Living situation		
Supervised	42	84
Un supervised	8	16
Prescribed medication		
Neuroleptic medication	42	84
Non neuroleptic medication	1	2
Neuroleptic with other medication	7	14
Family Income		
<Rs.3000	2	4
Rs.3000-5000	13	26
Rs.5000-10000	25	50
>Rs.10000	10	20
Onset of illness		
Before 6 month	11	22
1 - 3yrs	19	38
3 - 5yrs	10	20
above 5yrs	10	20

Table-1 shows the frequency and percentage distribution of demographic variables of schizophrenic clients.

With regard to age, 25(50%) clients were comes under 20 to 30 years, 15(30%) were 31-40 years, 4(8%) were 4-50 years and remaining 6(12%) were above 50 years of age.

With regard to sex, 45(90%) of schizophrenic clients were male and 5(10%) were female.

Regarding marital status, 19(38%) of clients were married, 31(62%) were single.

Regarding living situation, 42(84%) were supervised by their parents or guardian, 8(16%) were Unsupervised.

With regard to prescribed medication 42(84%) were comes under neuroleptic treatment, 1(2%) were comes under the non-narcoleptic medication, 7(14%) were belongs to neuroleptic with other medication.

Regarding income, 2(4%) of clients belongs to the income of <Rs.3000, 13(26%) were belongs to the income of Rs.3000 -5000, 25(50%) were Rs.5000-10000, 10(20%) were come under the income of above Rs.10000.

Regarding onset of illness,11(22%) clients onset were before 6 months, 19(38%) were1-3 years,10(20%) were 3-5 years and remaining 10(20%) were above 5 years.

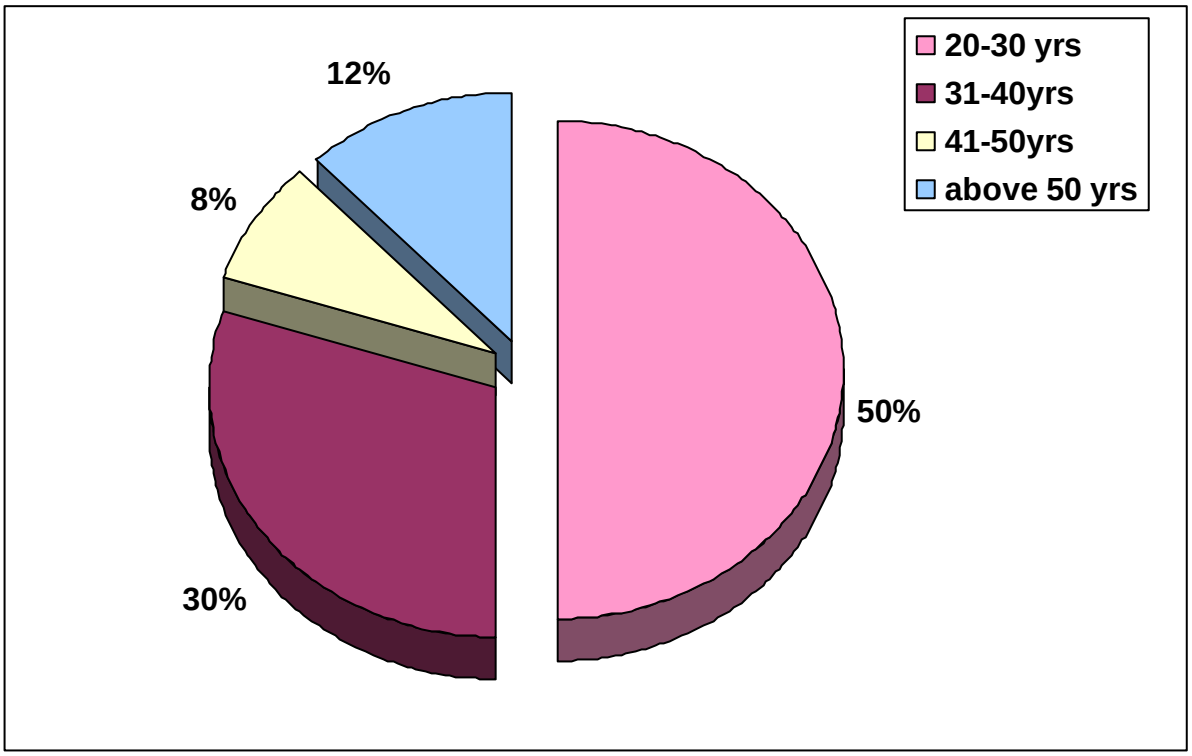

Fig.2: Percentage distribution of age of the sample

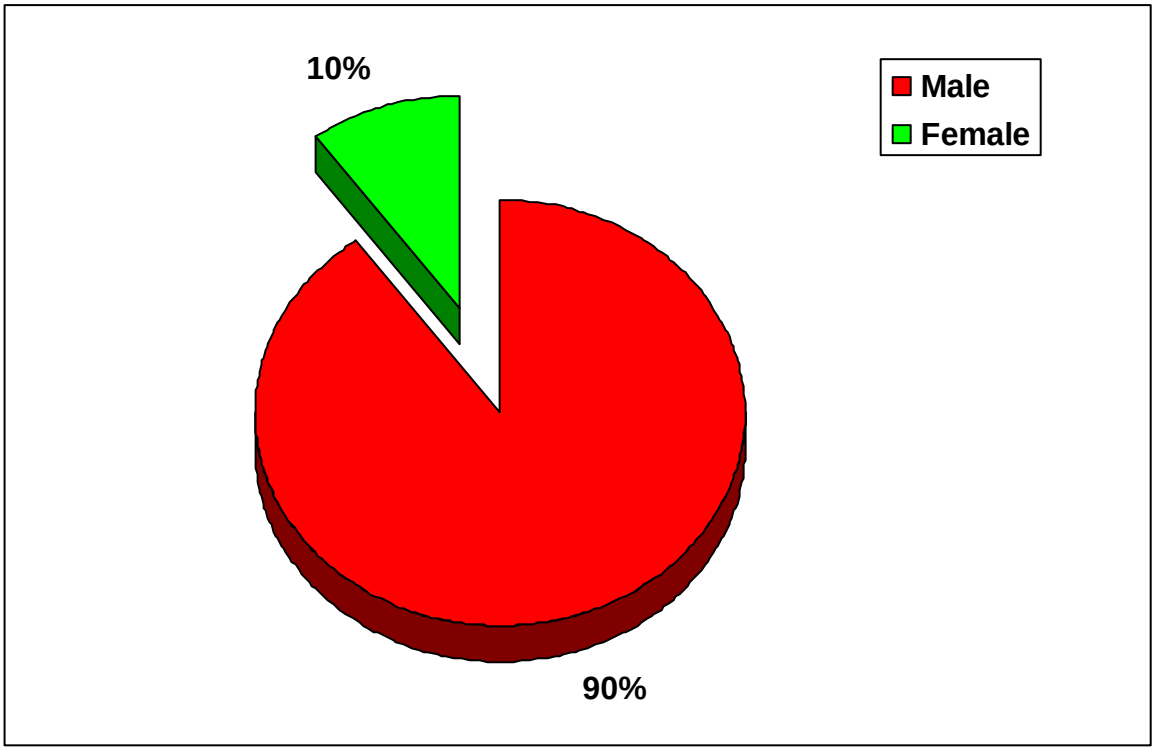

Fig.3:Percentage distribution of sex of the sample

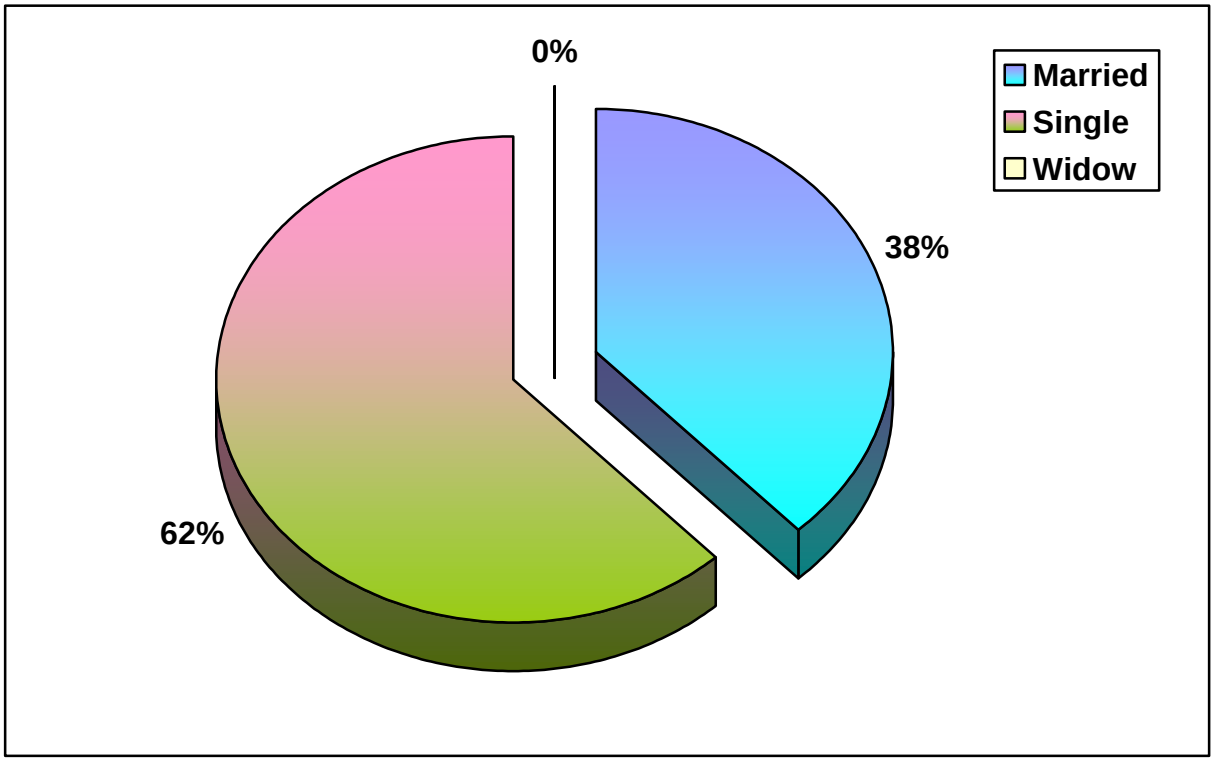

Fig.4: Percentage distribution of marital status of the sample

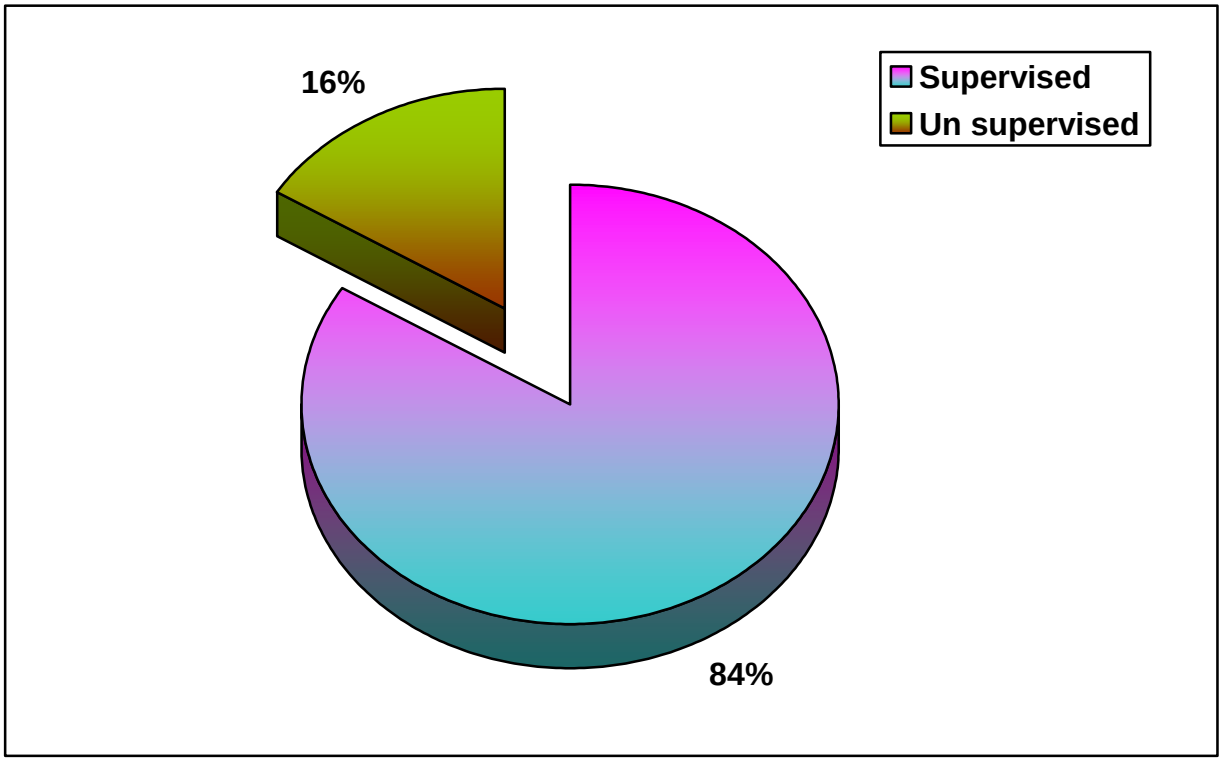

Fig.5: Percentage distribution of living situation of the sample

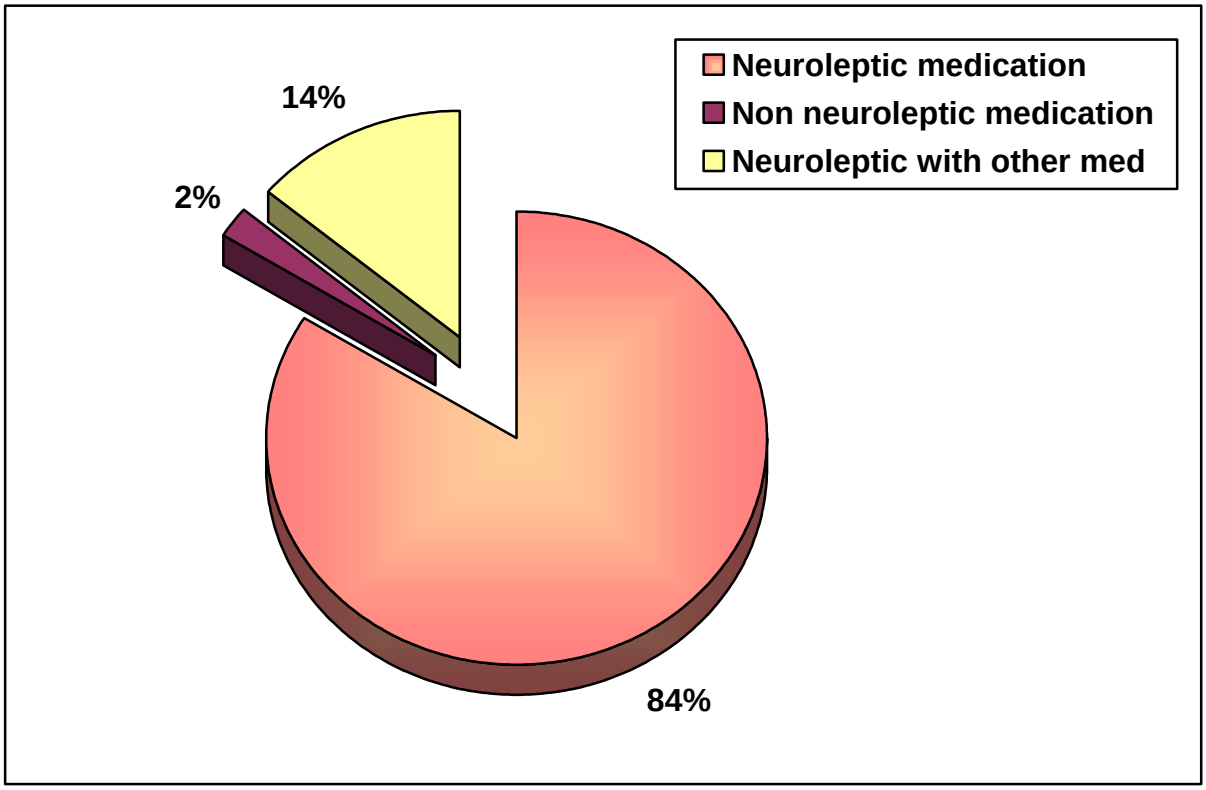

Fig. 6: Percentage distribution of prescribed medication of the sample

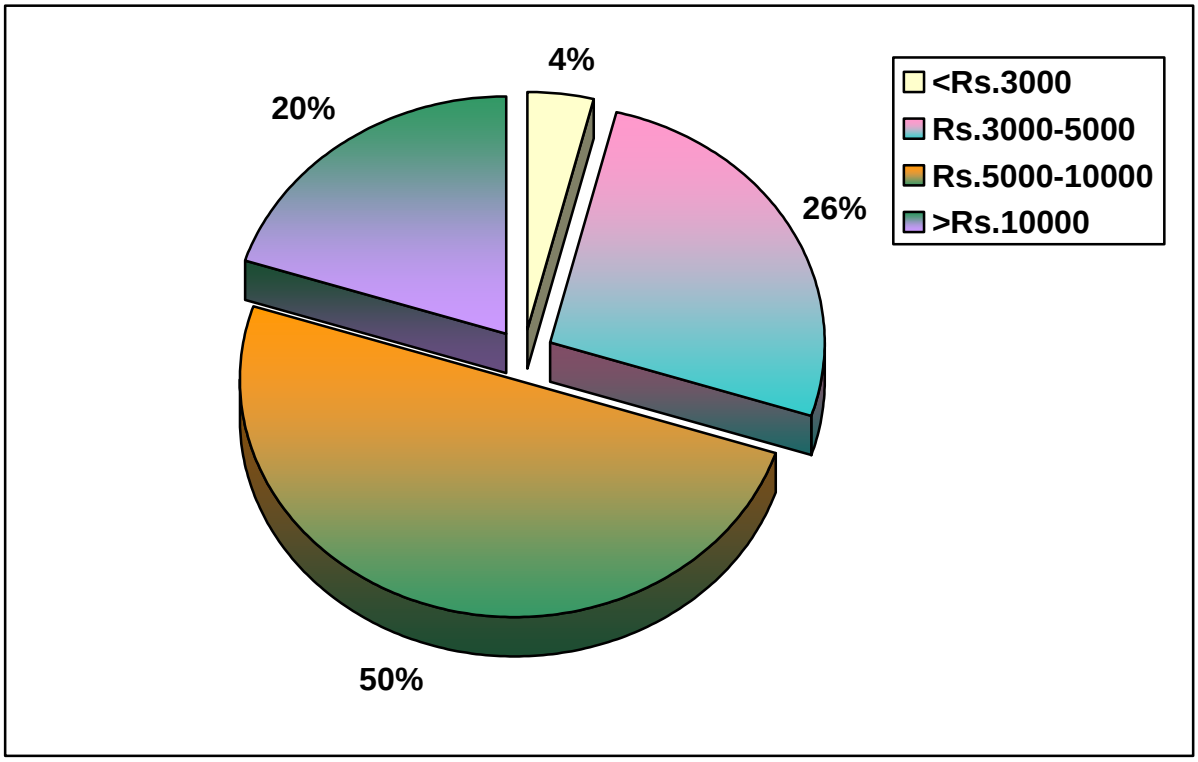

Fig.7: Percentage distribution of income of the sample

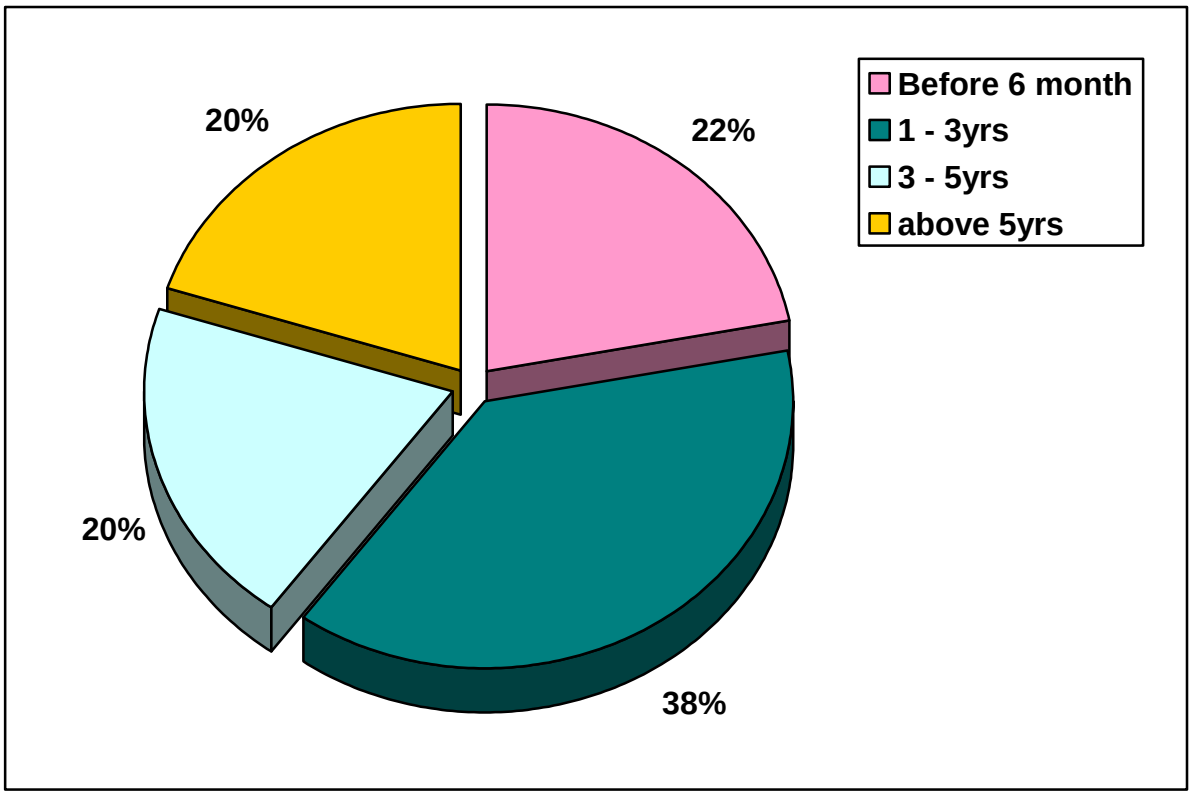

Fig.8: Percentage distribution of onset of illness of the sample

SECTION B

Table 2: Frequency and percentage distribution of level of compliance and non-compliance

n = 50

Variables	Mild (<50%)		Moderate (50 – 75%)		High (>75%)	
	No.	**%**	**No.**	**%**	**No.**	**%**
Compliance	45	90.0	5	10.0	0	0
Non-Compliance	49	98.0	1	2.0	0	0
Overall	**47**	**94.0**	**3**	**6.0**	**0**	**0**

Table 2 shows the frequency and percentage distribution of level of compliance and non-compliance of neuroleptic treatment.

The table illustrates that 90% of clients were having mild influence and 5% of clients were having moderate influence on compliance. In non compliance 49 % of clients were having mild influence and 1 % were having moderate influence on non compliance. overall 47(94.0%) client have mild influence and 3(6%) of clients have moderate influence irrespective of compliance and non compliance of neuroleptic treatment.

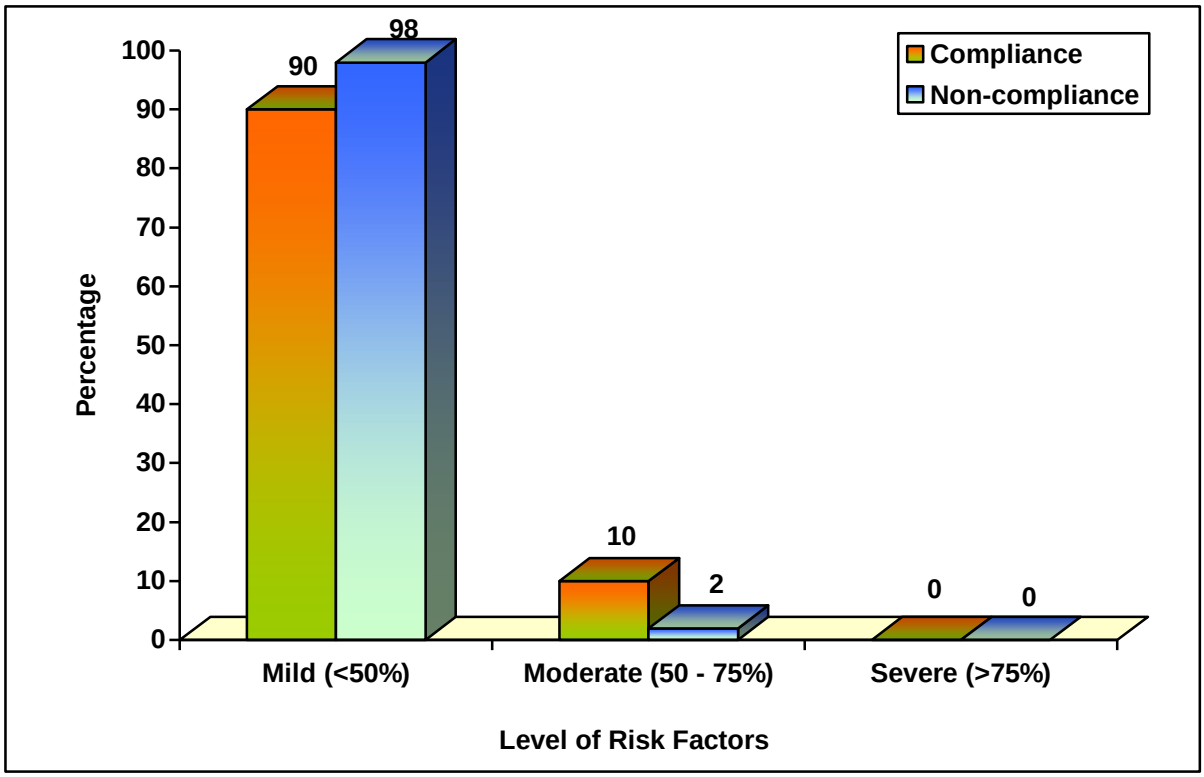

Fig.9: Percentage distribution of level of risk factors

Table 3: Mean and standard deviation of compliance and non-compliance

n = 50

Variables	Mean	S.D
Compliance	14.98	2.30
Non-Compliance	18.04	4.49
Overall	**33.02**	**5.39**

Table 3 shows the mean and standard deviation of compliance and non-compliance regarding risk factors for neuroleptic treatment.

The above table clearly indicates that mean score of risk factors compliance is 14.98 with standard deviation of2.30 and for non-compliance the mean score is18.04 with standard deviation of 4.49.

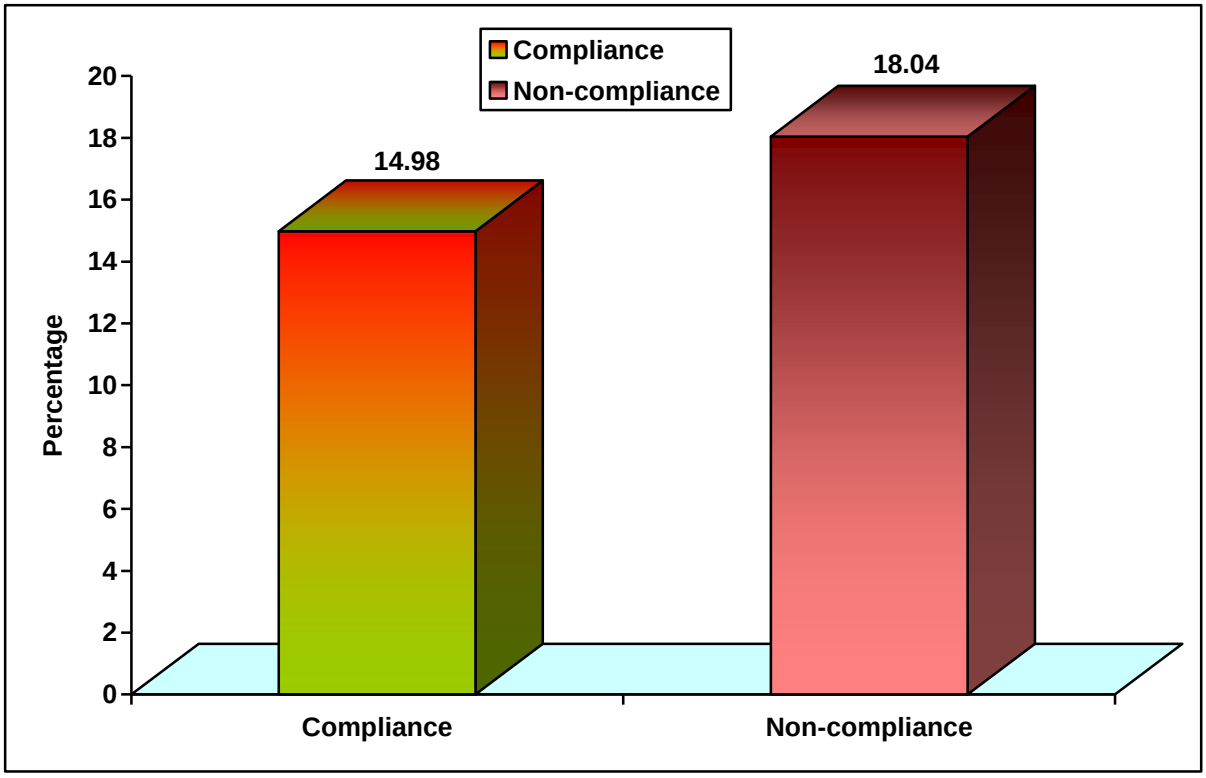

Fig.10: Comparison of mean scores of compliance and non-compliance

SECTION C

Table 4: Frequency and percentage distribution of level of attitude.

n= 50

Variable	Mild (<50%)		Moderate (50 – 75%)		High (>75%)	
	No.	%	No.	%	No.	%
Attitude	9	18.0	41	82.0	0	0

Table 4 shows percentage distribution of level of attitude on compliance and non-compliance.

18% of clients have unfavorable attitude, 82% of client have moderately favorable attitude.

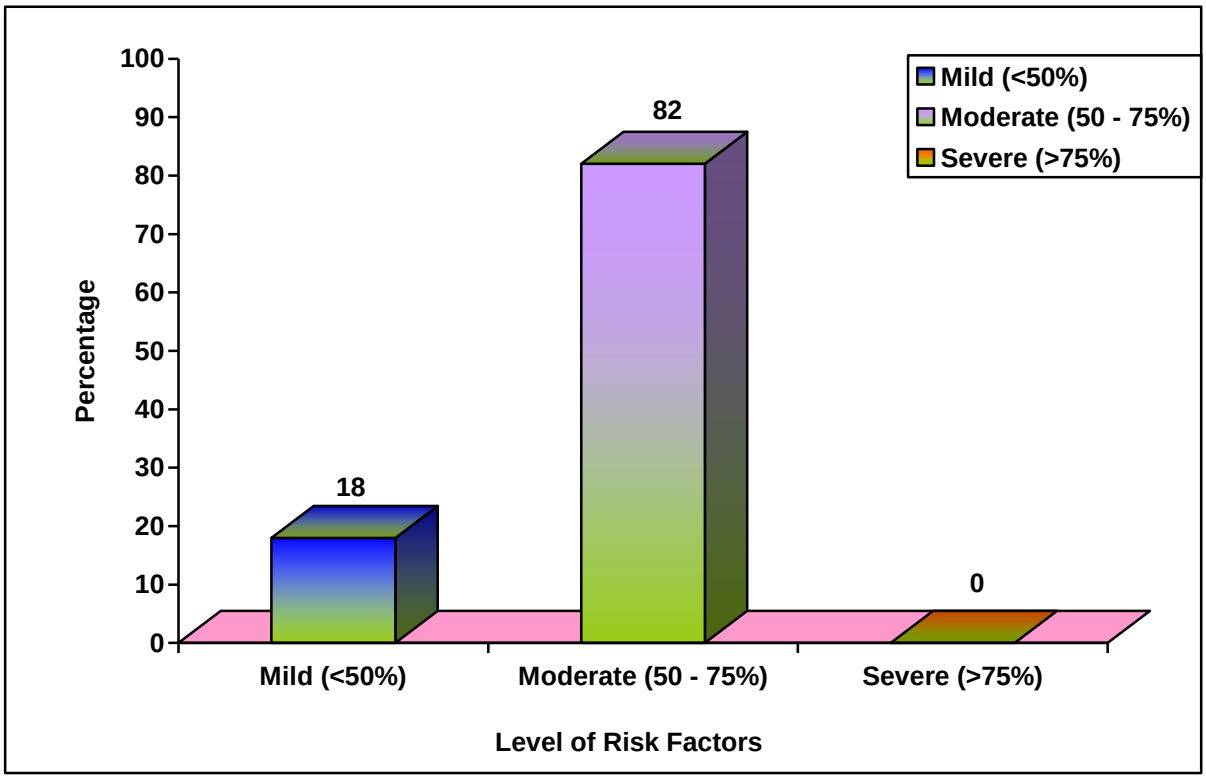

Fig.11: Percentage distribution of level of attitude

Table 5: Mean and standard deviation of attitude.

n= 50

Variable	Mean	S.D
Attitude	16.44	2.47

Table 5 shows that the mean and standard deviation of attitude regarding compliance and non-compliance of neuroleptic treatment. The mean score of attitude is 16.44 with standard deviation of 2.47.

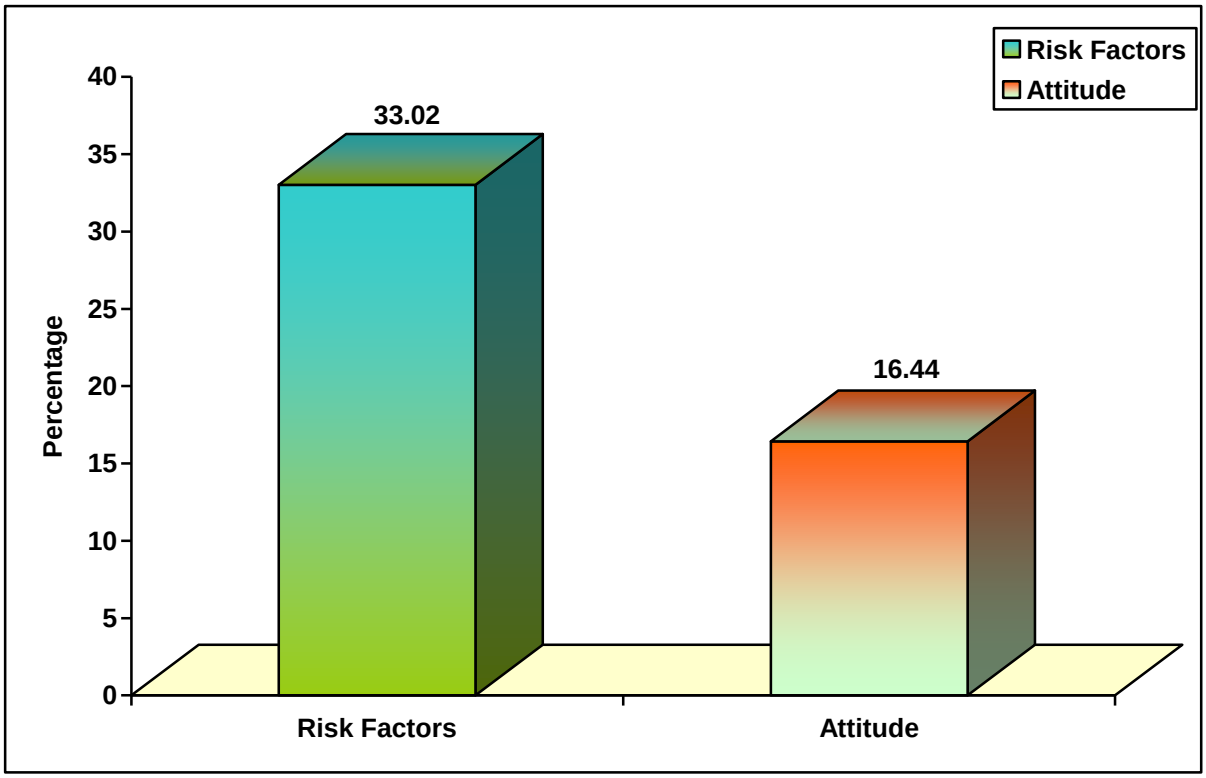

Fig.12: Comparison of mean scores of risk factors and attitude

Table 6: Assesment of level of risk factors of compliance and non-compliance

n= 50

Reasons for compliance	Degree of influence		
	None	Mild	Strong
1.Percieved daily benefit	22(44%)	10(20%)	18(36%)
2.Positive relation with prescribing clinician	17(34%)	15(30%)	18(36%)
3.positive relation with therapist	21(42%)	14(28%)	15(30%)
4.Positive family belief	10(20%)	14(28%)	26(52%)
5.Relapse prevention	27(54%)	9(18%)	14(28%)
6.Pressure/force	33(66%)	17(34%)	
7.Fear of rehospitalisation	28(56%)	14(28%)	8(16%)
8. No perceived daily benefit	33(66%)	10(20%)	7(14%)
9. Negative relation with prescribing clinician	38(76%)	7(14%)	5(10%)
10.Negative relation with therapist	38(76%)	7(14%)	5(10%)
11.Practitioner opposed to meds	37(74%)	8(16%)	5(10%)
12.Family/ friend opposed to meds	36(72%)	5(10%)	9(18%)
13.Access to treatment problems	31(62%)	15(30%)	4(8%)
14.Stigma over meds	25(50%)	15(30%)	4(8%)
15.Financial obstacles	31(62%)	12(24%)	7(14%)
16.Substance abuse	33(66%)	12(24%)	5(10%)
17.Denial of illness	29(58%)	16(32%)	5(10%)
18.Medication currently unnecessary	29(58%)	14(28%)	7(14%)
19. Distressed by side effects	26(52%)	19(38%)	5(10%)
20.Desire rehospitalisation	34(68%)	9(18%)	7(14%)

Table 6 shows that assessment of level of risk factors of compliance and non compliance.

In reasons for compliance, 44 % were none, 20 % were mildly influenced, 36 % were strongly influenced by perceived daily benefit.

With regard to positive relation with prescribing clinician, 34% were none, 30 % were mildly influenced and 36 % were strongly influenced

In positive relation with therapist, 42% were none, 28 % were mildly influenced, and 30 % were strongly influenced.

With regard to positive family belief, 20% were none, 28% were mildly influenced and 52 % were strongly influenced.

Regarding relapse prevention, 54% were none, 18% were mildly influenced, 28% were strongly influenced.

With regard to pressure/force 66 % were mildly influenced, and 34 % were moderately influenced.

Regarding fear of rehospitalization,56 % % were none, 28 % were mildly influenced, 16% Were strongly influenced .

In reasons for non compliance, no perceived daily benefit , 66% were none, 20% were mildly influenced & 14% Were strongly influenced.

With regard to negative relation with prescribing clinician, 76% % were none, 14% were mildly influenced, 10% Were strongly influenced.

Regarding negative relation with therapist, 76% were none, 14% were mildly influenced, and 10 % were strongly influenced .

Considering the practitioners opposed to meds, 74% were none, 16% were mildly influenced, and 10 % were strongly influenced.

Considering family/ friend opposed to meds, 72% were none, 10% were mildly influenced and 18 % were strongly influenced.

Regarding access to treatment problem, 62% were none, 30% were mildly influenced and 10 % were strongly influenced.

Considering stigma over meds, 74% were none, 16% were mildly influenced, and 8 % were strongly influenced.

Regarding financial obstacles, 62% were none, 24% were mildly influenced, and 14 % were strongly influenced.

With regard to substance abuse, 66% were none, 24% were mildly influenced, and 10 % were strongly influenced.

Regarding denial of illness, 58% were none, 32% were mildly influenced, and 10% were strongly influenced.

Considering medication currently unnecessary, 58% were none, 28% were mildly influenced and 14 % were strongly influenced.

With regard to distressed by side effects, 52% were none, 38% were mildly influenced and 10 % were strongly influenced.

Regarding desire rehospitalization, 68% were none, 18% were mildly influenced, and 14% were strongly influenced.

Table 7: Association of level of attitude with the demographic variables.

n = 50

Demographic Variables	Mild (<50%)		Moderate (50 – 75%)		Severe (>75%)		Chi-Square Value
	No.	%	No.	%	No.	%	
Age							$\chi^2 = 11.337$ d.f = 3 S*
20-30 yrs	3	6.0	22	44.0	-	-	
31-40yrs	2	4.0	13	26.0	-	-	
41-50yrs	0	0	4	8.0	-	-	
above 50 yrs	4	8.0	2	4.0	-	-	
Sex							$\chi^2 = 0.015$ d.f = 1 N.S
Male	8	16.0	37	74.0	-	-	
Female	1	2.0	4	8.0	-	-	
Marital status							$\chi^2 = 0.101$ d.f = 1 N.S
Married	3	6.0	16	32.0	-	-	
Single	6	12.0	25	50.0	-	-	
Widow	-	-	-	-	-	-	
Living situation							$\chi^2 = 0.195$ d.f = 1 N.S
Supervised	8	16.0	34	68.0	-	-	
Un supervised	1	2.0	7	14.0	-	-	
Prescribed medication							$\chi^2 = 8.543$ d.f = 2 S*
Neuroleptic medication	5	10.0	37	74.0	-	-	
Non neuroleptic medication	0	0	1	2.0	-	-	
Neuroleptic with other med	4	8.0	3	6.0	-	-	
Income							$\chi^2 = 3.471$ d.f = 3 N.S
<Rs.3000	0	0	2	4.0	-	-	
Rs.3000-5000	3	6.0	10	20.0	-	-	
Rs.5000-10000	6	12.0	19	38.0	-	-	
>Rs.10000	0	0	10	20.0	-	-	
Onset of illness							$\chi^2 = 4.617$ d.f = 3 N.S
Before 6 month	1	2.0	10	20.0	-	-	
1 - 3yrs	2	4.0	17	34.0	-	-	
3 - 5yrs	4	8.0	6	12.0	-	-	
above 5yrs	2	4.0	8	16.0	-	-	

*p<0.05, S – Significant, N.S – Not Significant

Table 7 clearly shows the association of level of attitude with the demographic variables.

The age and prescribed medication are significantly associated with attitude of compliance and non compliance of neuroleptic treatment.

Sex, marital status, living situation, income and onset of illness are not significantly associated with attitude of compliance and non compliance of neuroleptic treatment.

Table 8: Association of level of risk factors with the demographic variables.

n= 50

Demographic Variables	Mild (<50%)		Moderate (50 – 75%)		Severe (>75%)		Chi-Square Value
	No.	%	No.	%	No.	%	
Age							
20-30 yrs	1	2.0	24	48.0	-	-	$\chi^2 = 2.246$
31-40yrs	2	4.0	13	26.0	-	-	d.f = 3
41-50yrs	-	-	4	8.0	-	-	N.S
above 50 yrs	-	-	6	12.0	-	-	
Sex							$\chi^2 = 1.931$
Male	2	4.0	43	86.0	-	-	d.f = 1
Female	1	2.0	4	8.0	-	-	N.S
Marital status							$\chi^2 = 1.113$
Married	2	4.0	17	34.0	-	-	d.f = 1
Single	1	2.0	30	60.0	-	-	N.S
Widow	-	-	-	-	-	-	
Living situation							$\chi^2 = 0.608$
Supervised	3	6.0	39	78.0	-	-	d.f = 1
Un supervised	-	-	8	16.0	-	-	N.S
Prescribed medication							$\chi^2 = 1.030$
Neuroleptic medication	2	4.0	40	80.0	-	-	d.f = 2
Non neuroleptic medication	0	0	1	2.0	-	-	N.S
Neuroleptic with other med	1	2.0	6	12.0	-	-	
Income							
<Rs.3000	-	-	2	4.0	-	-	$\chi^2 = 0.655$
Rs.3000-5000	1	2.0	12	24.0	-	-	d.f = 3
Rs.5000-10000	1	2.0	24	48.0	-	-	N.S
>Rs.10000	1	2.0	9	18.0	-	-	
Onset of illness							
Before 6 month	1	2.0	10	20.0	-	-	$\chi^2 = 1.127$
1 - 3yrs	1	2.0	18	36.0	-	-	d.f = 3
3 - 5yrs	1	2.0	9	18.0	-	-	N.S
above 5yrs	-	-	10	20.0	-	-	

N.S – Not Significant

Table 8 shows that age, sex, marital status, sex and income are not significant with level of risk factors of compliance of neuroleptic treatment.

CHAPTER – V

DISCUSSIONS

This chapter discusses the findings of the study derived from statistical analysis. The problem stated was a study to assess the attitude on risk factors associated to compliance and noncompliance of neuroleptic treatment in Raju Hospital, Chennai.

Very few study only conducted in India regarding attitude on medication non-compliance and compliance which measured the attitudes and risk factors of patients. Compliance in this study is defined as degree to which the patient consistently follows the instruction given by the doctor regarding medication and treatment. For various reasons measuring compliance status accurately is a difficult process.

The first objective is to assess the attitude on compliance and non-compliance.

The attitude of schizophrenic patients towards medication and treatment are measured by modified (DAI) Drug attitude inventory. In this current study majority of patients have negative attitude towards medication irrespective of the compliance/non-compliance of the status.

A study regarding attitude on compliance and non-compliance were conducted in New Delhi in 2009.In that 38.7% of patients and family members had a positive attitude towards medication and treatment.

In this study majority were having moderately favorable attitude that is 82 % and 18% were having unfavorable attitude (negative attitude). No one is having favorable attitude (positive attitude) irrespective of compliance and non-compliance. The attitude score of DAI represent an indirect representation of compliance.

The second objective is to assess the risk factors of compliance and non-compliance of neuroleptic treatment.

The response to the modified ROMI open ended questions were grouped into reasons for compliance which consists of 7 question and reasons for non-compliance consists of 13 questions.

Babied 1986, Bellinger ET all done the research on medication compliance. In that 10% are estimated to be compliant and 76% of patients are estimated to be non-compliant.

This current study shows that 90% of clients were having mild influence and 5% of clients were having moderate influence on compliance. In non compliance 49 % of clients were having mild influence and 1 % were having moderate influence on non compliance. Overall 47(94.0%) clients have mild influence and 3(6%) of clients have moderate influence irrespective of compliance and non compliance of neuroleptic treatment.

It is likely that non-compliance rates are under estimated. And as it is an alarming finding, it requires great attention.

The third objective was to associate the level of risk factors on compliance & non-compliance of neuroleptic treatment with the demographic variables.

Number of risk factors is identified for non-compliance. One previous study revealed that Kelly et al, 2001 have found that side effects account for only 10% of the variance in self-reported compliance. In this study 48% of clients were influenced by side effects.

Positive relation with treating therapist 18% of the people were strongly influenced. In positive family belief 52% were strongly influenced. In 1992, Vaughn and Leaf 1996 have found that the cost of relapses not only by the patient but also the family members who often supervising, and their maintenance of relationship also influenced by the patient.

BARCO et al 1987 have considered stigma over medication, financial obstacles and side effects influence compliance. In this current study, 25% stigma over meds, 30%

substance abuse, 22% denial of illness and 32% were desired to be rehospitalised were influence the compliance.

The fourth objective was to associate the level of attitude on compliance and non-compliance of neuroleptic treatment with the demographic variables.

A number of demographic factors have been identified as bearing a relationship with non-compliance in those with a diagnosis of schizophrenic clients.

Gender is another demographic factor Atwood et al in 1995 found that men are less likely to comply than women. In this study women are less likely to comply than men. In this study also gender is a significant relation with attitude on compliance of neuroleptic treatment. Lenin et al. suggested that prescribed medication plays an important role in compliance. In my study also prescribed medication d.f=2, p is less than 0.05, which is significantly associated with level of attitude on compliance.

One study Tunnicliffe et al., (1992) found that lack of family support has been cited as an important predictor, but marital status does not influence. In this study also marital status does not influence much. But other factors like age and prescribed medications are much more influence and significant. Yung et al in 1997 found that 20 to 30 years of age people are associated with non-compliance.

In conclusion many patients are having negative attitude on compliance. Regarding risk factor, the factors which are significantly influence should be incorporated into any programmed designed to improve over all attitude.

CHAPTER – VI

SUMMARY, RECOMMENDATIONS, NURSING IMPLICATIONS AND LIMITATIONS

SUMMARY

The research problem was stated as "A study to assess the attitude on risk factors associated with compliance and non-compliance of neuroleptic treatment among patient with schizophrenia in Raju Hospital at Chennai.

The objectives were:

1. To assess the attitude on compliance and non compliance of neuroleptic treatment among patients with schizophrenia.
2. To assess the risk factors on compliance and non-compliance of neuroleptic treatment among patients with schizophrenia
3. To associate the level of risk factors on compliance & non-compliance of neuroleptic treatment with the demographic variables.
4. To associate the level of attitude on compliance and non-compliance of neuroleptic treatment with the demographic variables

The Assumptions made were

1. Non-compliance of the neuroleptic treatment has a strong influence on relapse of schizophrenic clients.
2. Relapse can have long term effects on outcome of schizophrenic clients
3. Health professional has an important role to play in guiding the family members regarding prevention of relapse.

The major findings of the study were

Out of 50 patients, 90% of clients were having mild influence and 5% of clients were having moderate influence on compliance. In non compliance, 98% of clients were having mild influence and 2% of clients were having moderate influence on non compliance. Regarding attitude, 18% of client have unfavorable attitude and 82 % of clients were having moderately favorable attitude. As the above findings proved that the assumptions made in this study were true.

NURSING IMPLICATIONS

The investigator had derived the following implications from the study which are vital concern in the field of nursing practice, nursing administration, nursing education, and nursing research.

Nursing Practice

1. The psychiatric nurse as a service provider, as a care giver, should periodically organize awareness programme through counseling and in service educational programme within the clinical settings.
2. The nurse must implement information, education, communication (IEC) to provide awareness to the health professionals.
3. As a service provider the nurse should provide self-care modules, personal management module on drug compliance.
4. The community nurse, as a service provider should conduct mass education programmed on medication compliance and non-compliance and its positive, negative attitude of patients and family and its impact, appropriately assigned audio visual aids

Nursing Education

1. Nurse educator should actively involve in the process of organizing continuing education like conducting in-service education in their institutions regarding compliance and noncompliance of neuroleptic treatment.
2. Make available literature related to neuroleptic drug and its compliance and noncompliance, impact, risk factors, related disorders and its management.

Nursing Administration

1. As an administrator the psychiatric nurse should design formal teaching programmed on drug compliance for family in the selected community.
2. Provide opportunity for nurses to attend training programmed.
3. The nurse must be instrumental at point out relevant policies of the state and central level to ensure effective program to educate the public and facilitate optimal allocation for implementing the programmed.
4. Create an intersect oral network to control disorders.

Nursing Research

1. Encourage further studies on medication compliance and noncompliance among family members and patients, caregivers in different settings.
2. More research needs to be conducted on the aspects of medication compliance and noncompliance, risk factors, attitude, education programmed and in effective therapies.

RECOMMENDATIONS

A similar study can be replicated on a large sample at state level.

LIMITATION

Minor difficulties found during the study period as the patients were not co-operating.

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APPENDIX – A

LIST OF EXPERTS FOR CONTENT VALIDITY OF THE TOOL

1. **Mrs.Shanthi,R.N.,R.M., M.Sc (N).,**
   Professor, Mental Health Nursing,
   SRMC College of Nursing,
   Porur, Chennai.

2. **Mrs.Neelakshi, R.N., R.M., M.Sc (N),.**
   Professor, Mental Health Nursing,
   SRMC College of Nursing,
   Porur, Chennai.

3. **Mr.Manigandan** , MSW.,
   Social Worker ,
   Raju Hospital,
   Chennai.

4. **Mrs.Grace, R.N., R.N., M.Sc (N),.**
   Professor, Mental Health Nursing,
   Matha College of Nursing,
   Chennai.

5. **Dr.K.Vijayakumar, M.B.B.S., DPM.,**
   Raju Hospital,
   Chennai.

LETTER SEEKING EXPERTS OPINION FOR CONTENT VALIDITY

From

Ms.W.Jerone L. Benedicta
M.Sc.(N) II Year,
Vel R.S Medical College – College of Nursing,
Avadi, Chennai – 600 062.

To

Respected Madam/Sir,

Sub: Requisition for expert opinion on suggestion for content validity of the tools.

I am Ms. W.Jerone L. Benedicta, a student of M.Sc.(Nursing)- II year at Vel R.S Medical College - College of Nursing, Avadi, Chennai – 62, affiliated to Dr.M.G.R.Medical University, Chennai.

As a partial fulfillment of the requirement in the M.Sc. Nursing Programme, I have to complete a dissertation the topic I have selected is **"A study to assess the attitude on risk factors associated with compliance and noncompliance of neuroleptic treatment among patients with schizophrenia, in Raju Hospital at Chennai".**

Herewith I am sending the developed tools for content validity and for your expert opinion & valuable suggestions.

Thanking you,

Yours sincerely,

(W.JERONE .L BENEDICTA)

Enclosures:

1. Statement and objectives of the study
2. Blue print of the tools
3. Content validity certificate

CERTIFICATE FOR CONTENT VALIDITY

This is to certify that the tools developed by **Ms.W.Jerone L. Benedicta,** M.Sc. Nursing student Vel R.S. Medical College – College of Nursing, Chennai on the topic, **"A study to assess the attitude on risk factors associated with compliance and noncompliance of neuroleptic treatment among patients with schizophrenia, in Raju Hospital at Chennai"** is validated by the undersigned and she can proceed with this tool to conduct the main study.

Place : Chennai

Date : **Signature**

APPENDIX – B

INTRODUCTION

Dear Participants,

I am Miss.Jerone L. Benedicta, M.Sc.(N) II Year student from Vel R.S.Medical College – College of Nursing, Avadi, Chennai. I would like to assess the attitude on risk factors associated with compliance and non-compliance of neuroleptic treatment among patients with schizophrenia. I request you to participate in the study. A rating scale will be used to collect data regarding your attitude and risk factors on compliance and non compliance of neuroleptic treatment. I assure you that the responses given by you will be used only for my study purpose. So I request you to kindly give your full co-operation and willingness.

Thanking you.

DEMOGRAPHIC VARIABLES

1.Age

20-30 yrs

31-40yrs

41-50yrs

above 50 yrs

2.Sex

Male

Female

3.Marital status

Married

Single

Widow

4.Living situation

Supervised

Un supervised

5.Prescribed medication

Neuroleptic medication

Non neuroleptic medication

Neuroleptic with other medication

6. Family Income

<Rs.3000

Rs.3000-5000

Rs.5000-10000

>Rs.10000

7.Onset of illness

Before 6 month

1 - 3yrs

3 - 5yrs

above 5yrs

MEDICATION QUESTIONNAIRE

S.No.	Contents	True	False
1.	I don't need to take medication once I feel better		
2.	For me, the good things about medication outweigh the bad		
3.	I feel strange, "doped up", on medication		
4.	Even when I am not in hospital I need medication regularly		
5.	If I take medication, it's only because of pressure from other people		
6.	I am more aware of what I am doing, of what is going on around me, when I am on medication		
7.	Taking medications will do me no harm		
8.	I take medications of my own free choice		
9.	Medications make me feel more relaxed		
10.	I am no different on or off medication		
11.	The unpleasant effects of medication are always present		
12.	Medication makes me feel tired and sluggish		
13.	I take medication only when I feel ill		
14.	Medications are slow-acting poisons		
15.	I get along better with people when I am on medication		
16.	I can't concentrate on anything when I am taking medication		
17.	I know better than the doctors when to stop taking medication		
18.	I feel more normal on medication		
19.	I would rather be ill then taking medication		
20.	It is unnatural for my mind and body to be controlled by medications		
21.	My thoughts are clearer on medication		
22.	I should keep taking medication even if I feel well		
23.	Taking medication will prevent me from having a breakdown		
24.	It is up to the doctor to decide when I should stop taking medication		
25.	Things that I could do easily are much more difficult when I am on medication		
26.	I am happier and feel better when I am taking medications		
27.	I am given medication to control behaviour that other people (not myself) don't like		
28.	I can't relax on medication		
29.	I am in better control of myself when taking medication		
30.	By staying on medications I can prevent myself getting sick		

RATING OF MEDICATION INFLUENCE SCALE

PART I: REASONS FOR COMPLIANCE

"ARE YOU WILLING TO TAKE YOUR MEDICATION BECAUSE":

1. PERCEIVED DAILY BENEFIT

You believe the medicine helps you feel better?

2. POSITIVE RELATION WITH PRESCRIBING CLINICIAN NA

Your relationship with your prescribing doctor influences you?

3. POSITIVE RELATION WITH THERAPIST

Your relationship with your therapist influences you?

4. POSITIVE FAMILY BELIEF

Someone in your family or a friend believes that you should

take medicine?

5. RELAPSE PREVENTION

You believe taking medication prevents your illness or symptoms NA from returning?

6. PRESSURE/FORCE

You are pressured or forced to take medication?

7. FEAR OF REHOSPITALIZATION

You are afraid of being rehospitalized?

8. NO PERCEIVED DAILY BENEFIT

You believe medication does not help you feel better?

9. NEGATIVE RELATION WITH CLINICIAN

Your bad relationship with your prescribing doctor influences

you?

10. NEGATIVE RELATION WITH THERAPIST

Your bad relationship with your therapist influences you?

11. PRACTITIONER OPPOSED TO MEDS

One of your practitioners does not believe you should be taking the medication?

12. FAMILY/FRIEND OPPOSED TO MEDS

Someone whose opinion is important to you is against your taking the medication?

13. ACCESS TO TREATMENT PROBLEMS

You have difficulty getting to your appointments, and/or difficulty getting meds?

14. EMBARRASSMENT OR STIGMA OVER MEDS/ILLINESS

You feel embarrassed about taking medication?

15. FINANCIAL OBSTACLES

You don't have enough money to pay for treatment or medication?

16. SUBSTANCE ABUSE

You would rather take other drugs or alcohol?

17. DENIAL OF ILLNESS

You don't believe you have a mental illness?

18. MEDICATION CURRENTLY UNNECESSARY

You don't believe that you currently need the medication?

19. DISTRESSED BY SIDE EFFECTS

The side effects of the medicine are too upsetting to you?

20. DESIRES REHOSPITALIZATION

You feel more comfortable in the hospital?

None Mild Strong Not Assessable

முகவுரை

வணக்கம்.

நான் வேல் ஆர்.எஸ். மருத்துவ கல்லூரி-செவிலியர் கல்லூரியில் இரண்டாம் ஆண்டு முதுகலை செவிலியர் கல்வி பயிலும் மாணவி. நான் என் படிப்பின் ஒரு பகுதியாக **மனநோய் மாற்ற மருந்து எடுப்பதன் மூலம் ஏற்படும் பயன்பாட்டு மதிப்பீட்டைப் பற்றியும் அதன் பார்வை தொகுப்பு பற்றியும்** ஒரு ஆய்வை நடத்துகின்றேன். இதன் தொடர்பாக நான் தங்களை எனது ஆய்வின் பங்கேற்பாளராக இணைத்துக் கொள்ள மிக தாழ்மையுடன் கேட்டுக்கொள்கிறேன். இதன் தொடர்பாக நான் கேட்கும் கேள்விகளுக்கு சரியான உங்கள் பதிலை தெரிவிக்கவும். உங்கள் பதிலை நான் என் ஆய்விற்காக மட்டுமே பயன் படுத்துவேன் என்று உறுதியளிக்கிறேன்.

நன்றி!

தகவலாளர் விவரம்

கீழ்க்கண்ட விபரங்களுக்கு தக்க விடையளிக்கவும்:

1. வயது
   - அ) 20 – 30 வருடங்கள்
   - ஆ) 31 – 40 வருடங்கள்
   - இ) 41 – 50 வருடங்கள்
   - ஈ) 50-க்கு மேல்

2. இனம் / பால்
   - அ) ஆண்
   - ஆ) பெண்

3. திருமண விபரம்
   - அ) திருமணமானவர்
   - ஆ) திருமணமாகாதவர்
   - இ) விதவை

4. வாழும் சூழ்நிலை
   - அ) கண்காணிப்புக்குள் இருப்பவர்
   - ஆ) கண்காணிப்பு இல்லாதவர்

5. மனநோய் (உளப்பிணி) மாற்ற மருந்து
   - அ) மனநோய் மாற்ற மருந்து மட்டும்
   - ஆ) மனநோய் அல்லாத மருந்து
   - இ) மனநோய் மாற்ற மருந்து வேறு மருந்தும்

6. குடும்ப வருமானம்
   - அ) 3000க்கு கீழ்
   - ஆ) 3000 – 5000 வரை
   - இ) 5000 – 10000 வரை
   - ஈ) 10000க்கு மேல்

7. நோயின் தொடக்கம்
   - அ) 6 மாதத்திற்கு
   - ஆ) 1 – 3 வருடங்கள்
   - இ) 3 – 5 வருடங்கள்
   - ஈ) 5-வருடங்களுக்கு மேல்

மருந்து குறித்த பார்வை பற்றிய தொகுப்பு

வ.எண்.	பொருளடக்கம்	சரி	தவறு
1	ஒரு முறை நலமாக இருப்பதாக உணர்ந்தால் எனக்கு மருத்துவம் தேவையில்லை		
2	நல்ல விஷயங்களை விட மருத்துவத்தை பற்றிய மோசமான விஷயங்கள் பெரும் தாக்கத்தை ஏற்படுத்துகிறது.		
3	மருந்துகளை உட்கொள்வதால் நான் வித்தியாசமாக உணர்கிறேன்		
4	சிகிச்சையளிக்கும் போது போதையில் இருப்பதாக வித்தியாசமாக உணர்கிறேன்.		
5	நான் மருத்துவமனையில் இருந்தாலும் எனக்கு தொடர்ந்து சிகிச்சை தேவை.		
6	நான் சிகிச்சை எடுத்துக் கொள்வது பிறரின் வற்புறுத்தலுக்காகத் தான் மருந்து எடுக்கும் போது		
7	நான் என்ன செய்கிறேன், என்னைச் சுற்றி என்ன நடக்கிறது என்பதைப் பற்றி தெளிவாக இருக்கிறேன்.		
8	சிகிச்சை பெறுவது, எவ்விதத்திலும் என்னை பாதிக்காது.		
9	நான் சிகிச்சை எடுத்துக் கொள்வது எனது விருப்பத்தினால் தான்.		
10	சிகிச்சை, என்னை மிகவும் இயல்பாக இருக்க வைக்கிறது.		
11	சிகிச்சையில் இருந்தாலும் இல்லை என்றாலும் வித்தியாசம் தெரியவில்லை.		
12	சிகிச்சையின் விரும்பத்தகாத விளைவுகள் தொடர்ந்து இருக்கிறது.		
13	சிகிச்சை என்னை களைப்படைய வைக்கிறது. சோம்பி இருக்கச் செய்கிறது.		
14	நான் விரும்பும்போது மட்டுமே நான் சிகிச்சை எடுத்துக் கொள்கிறேன்.		
15	மருந்து உட்கொள்வது, மெதுவாக கொல்லும் விஷம்.		

வ.எண்.	பொருளடக்கம்	சரி	தவறு
16	நான் சிகிச்சை எடுத்துக் கொள்ளும் போது பிறருடன் நல்ல முறையில் நடந்து கொள்கிறேன்.		
17	சிகிச்சையில் இருக்கும்போது எதிலும் முழுமையாக ஈடுபாடு இருப்பதில்லை.		
18	எப்போது சிகிச்சையை நிறுத்த வேண்டும் என்று மருத்துவர்களை விட எனக்கு நன்றாக தெரியும்.		
19	சிகிச்சையில் உள்ள பொழுது மிகமிக இயல்பாக இருக்கிறேன்.		
20	சிகிச்சை பெறுவதைவிட நோயோடு இருப்பது பரவாயில்லை.		
21	சிகிச்சையால் எனது மனதையும் உடலையும் கட்டுப்படுத்துவது இயல்புக்கு மாறானது.		
22	சிகிச்சை பற்றிய சிந்தனை மிகவும் தெளிவாக உள்ளது.		
23	நான் நலமாக இருப்பதாக உணர்ந்தாலும், சிகிச்சை எடுத்து கொள்ள வேண்டும்.		
24	சிகிச்சை பெறுவது, மருந்து உட்கொள்வது நான் குலைந்து போவதை தடுக்கும்.		
25	மருத்துவரே நான் எப்பொழுது சிகிச்சையை நிறுத்த வேண்டும் என்று முடிவு செய்ய வேண்டும்.		
26	சிகிச்சையில் இல்லாதபோது நான் சுலபமாக செய்யும் வேலைகள் கூட மிகவும் சிரமமாக தெரிகிறது.		
27	எனக்கு சிகிச்சை அளிக்கப்படுவது எனது நடவடிக்கை பிறரால் சகிக்க முடியவில்லை என்பதால் தான் எனக்கு சிகிச்சை அளிக்கப்படுகிறது.		
28	சிகிச்சையின் போது நான் ஓய்வாக இருக்க முடியாது.		
29	சிகிச்சை எடுக்கும்போது நான் என்னை மிகவும் கட்டுப் பாட்டுக்குள் இருக்கிறேன்.		
30	தொடர்ந்து சிகிச்சையில் இருக்கும் போது நோய்வாய் படுவதிலிருந்து பார்த்துக் கொள்கிறேன்.		

மருந்து உட்கொள்ளுதலின் பயன்பாட்டு மதிப்பீடு

வ.எண்.	வினாக்கள்	ஒ	மி	உ
1	**தினமும் கிடைக்கும் நலன்** மருந்து உங்களை குணமாக்குகிறது என்று நம்புகிறீர்களா?			
2	**மருத்துவருடன் நல்ல உறவு** மருத்துவருடன் உங்கள் உறவு உங்களில் தாக்கம் ஏற்படுத்துகிறதா? மருத்துவருடன் உள்ள உறவால் ஏற்படும் தாக்கம்			
3	**ஆலோசகரின் உறவு** ஆலோசகருடன் உள்ள உறவு உங்களில் ஏற்படுத்தும் தாக்கம்			
4	**குடும்பத்தின் மீதுள்ள மேம்பட்ட நம்பிக்கை** உங்கள் குடும்பத்தில் உள்ள ஒருவர் அல்லது நண்பர் நீங்கள் மருந்து எடுத்துக் கொள்ல வேண்டும் என நம்புகிறீர்களா?			
5	**தடுப்பு** நோய் அல்லது நோய்க்கான அறிகுறிகள் மீண்டும் வருவதிலிருந்து மருந்து எடுத்துக் கொள்ளுதல் தடுக்கிறது என்று நம்புகிறீர்களா?			
6	**அழுத்தம் / வற்புறுத்தல்** மருத்து எடுத்துக் கொள்ள வேண்டுமென்ற நிர்பந்திக்கப் படுகிறீர்களா? வலியுறுத்தப்படுகிறீர்களா?			
7	**மீண்டும் மருத்துவமனையில் அனுமதிக்கப்படும் பயம்** நீங்கள் மீண்டும் மருத்துவமனையில் அனுமதிக்கப்படுவீர்கள் என்று பயப்படுகிறீர்களா? நீங்கள் தொடர்ந்து மருந்து உட்கொண்டாலும் சில நேரங்களில் மருந்து எடுத்துக் கொள்ள வேண்டியதில்லை என்று நினைக்கலாம் அல்லது தடுக்கலாம். அதற்கான முக்கிய காரணங்கள் என்ன? (இந்த மாதத்திற்கு) இப்பொழுது மற்றவர்கள் மருந்து உட்கொள்ள ஏன்			

வ.எண்.	வினாக்கள்	ஒ	மி	உ
	தயங்குகிறீர்கள் என்பதை நான் சொல்கிறேன். இவற்றுள் ஏதாவது உங்களுக்கு ஒத்துப்போகிறதா? நீங்கள் மருந்து உட்கொள்ள தயங்குவதற்கு காரணம்			
8	**தினமும் பயன் இருப்பதாக தெரியவில்லை** மருந்து உட்கொள்வதால் முன்னேற்றம் இருப்பதாக தெரியவில்லை.			
9	**மருத்துவருடன் உள்ள எதிர்மறையான உறவு** மருத்துவருடன் நம்பகமற்ற உங்கள் உறவு உங்கள் மீது பாதிப்பை ஏற்படுத்துகிறதா?			
10	**ஆலோசகருடன் உள்ள எதிர்மறையான உறவு** ஆலோசகர் மீது நம்பகமற்ற உங்கள் உறவு உங்கள் மீது பாதிப்பை ஏற்படுத்துகிறதா?			
11	இந்தத்துறையில் உள்ள உங்களுக்கு தெரிந்த மருத்துவர் நீங்கள் மருந்து எடுத்துக் கொள்வது தேவை என்று நம்பவில்லை?			
12	**குடும்பம் / நண்பர் எதிர்ப்பு** உங்களுக்கு மிகவும் வேண்டப்பட்டவர் நீங்கள் மருந்து எடுத்துக் கொள்வதற்கு எதிர்ப்பு தெரிவிக்கிறார்.			
13	**சிகிச்சை பெற வாய்ப்பு கிட்டுவதில் உள்ள சிக்கல்கள்** சிகிச்சை பெற முன் அனுமதி பெறுவது போன்றவற்றில் சிக்கல் சிரமம் உள்ளது.			
14	**நோயுற்றிருப்பது, தர்ம சங்கடம், சிகிச்சை பெறுவதில் அவமானம்** நீங்கள் மருத்துவ சிகிச்சை பெறுவதை அவமானமாக உணர்கிறீர்களா?			
15	**வசதியின்மை ஒரு தடை** சிகிச்சைக்கு மருந்து உட்கொள்வதற்கு உங்களிடம் போதிய பணவசதியில்லையா?			
16	**போதைப் பழக்கம்** நீங்கள் போதைப்பொருள் அல்லது மது			

வ.எண்.	வினாக்கள்	ஒ	மி	உ
	உட்கொள்கிறீர்களா?			
17	**நோயை மறப்பது** உங்களுக்கு மனநோய் இருப்பதை ஏற்றுக்கொள்ள மறுக்கிறீர்களா?			
18	**சிகிச்சை / மருந்து உட்கொள்வது தற்போது தேவையற்றது** தற்போது மருந்து உட்கொள்ள வேண்டும் என்று நீங்கள் நம்பவில்லை.			
19	**பக்கவிளைவுகள் பற்றிய அச்சம்** பக்கவிளைவுகள் பற்றிய அச்சம் உங்களுக்கு உள்ளதா?			
20	**மீண்டும் மருத்துவமனையில் சேர விருப்பம்** மருத்துவமனையில் நீங்கள் மிகவும் நலமாக உணர்கிறீர்களா?			

VEL R.S. Medical College

(College of Nursing)

Owned by R.S. Trust

(Approved by Govt. of Tamil Nadu,
Indian Nursing Council, New Delhi, Tamil Nadu Nurses & Midwives Council &
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To

The Director
Raju Hospital
T-nagar, chennai.

Sub : Seeking permission for conducting main study.

Respected Sir / Madam,

This is to introduce **Ms. W.Jerone (Mental Health Nursing) Master Degree Nursing student** of this college. She has selected the following topic for her research study to be submitted to the Tamil Nadu Dr. MGR Medical University as partial fulfillment of the master degree in nursing program.

The topic for the study is, **"A study to assess the attitude on risk factors associated with compliance and non compliance of neuroleptic treatment among patients with schizophrenia in selected Hospital Chennai."**

She is interested in conducting the study at your esteemed institution.

I assure you that our student will abide by the rules and regulations of the setting. I request you at most help in regard to the same.

Thanking you,

Permitted

Raju Hospital
42, South Usman Road.
T Nagar, Madras-600 017

Mrs.M.Anuradha
VEL R. S. MEDICAL COLLEGE
PRINCIPAL
(COLLEGE OF NURSING)
42, AVADI-ALAMATHI ROAD
VELLANUR CHENNAI-62

CERTIFICATE OF ENGLISH EDITING

TO WHOMSOEVER IT MAY CONCERN

This is to certify that the dissertation work **"A study to assess the attitude on risk factors associated to compliance and non compliance for neuroleptic treatment among patients schizophrenia."** done by **Ms. W. Jerone L Benedicta** II year M.Sc (Nursing) student of Vel.R.S Medical College, College of Nursing, Avadi, Chennai, is edited forEnglish Language appropriateness by _____

Name : L. WILLIAM LAWRENCE.

Signature : L. William Lawrence

08/12/2010

L. WILLIAM LAWRENCE, M.Sc., M.Ed, M.Phil.
Head Master
St. Mary's R.C. Middle School,
Koneripati, Gengavalli T.k, Salem Dt.

CERTIFICATE OF TAMIL EDITING

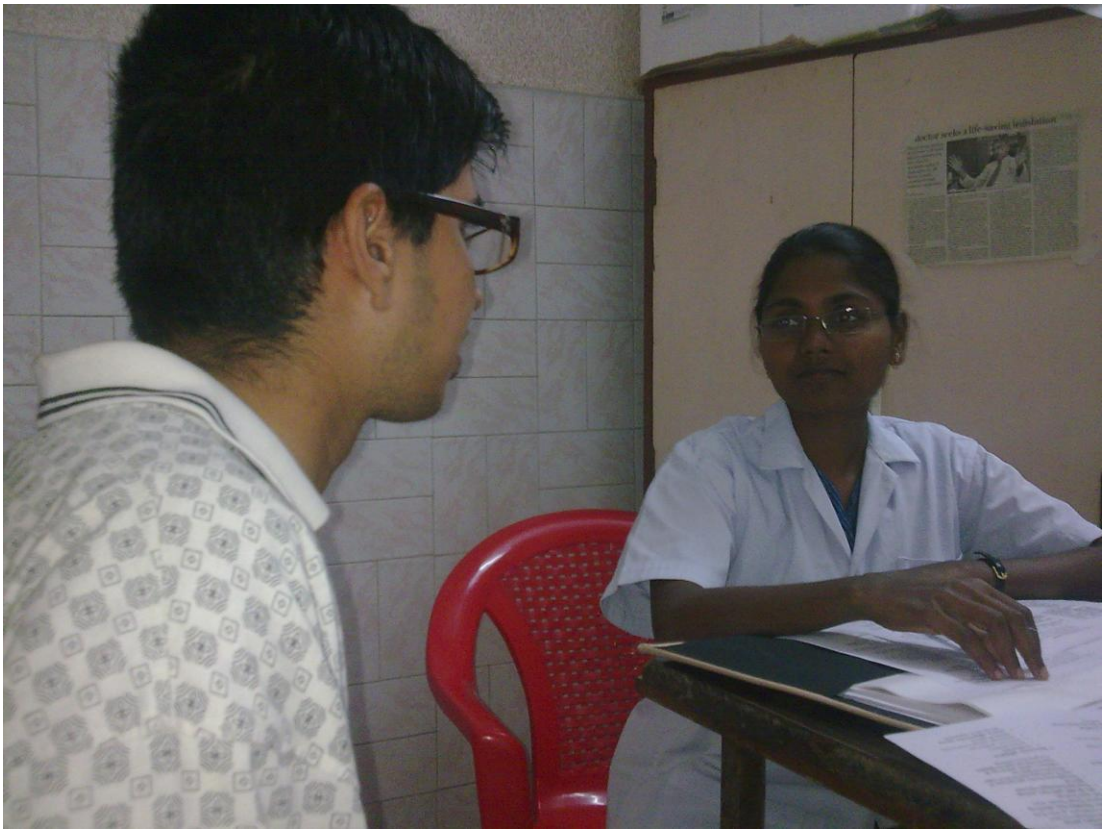
TO WHOMSOEVER IT MAY CONCERN

This is to certify that the dissertation work **"A study to assess the attitude on risk factors associated to compliance and non compliance for neuroleptic treatment among patients schizophrenia."** done by **Ms. W. Jerone L Benedicta** II year M.Sc (Nursing) student of Vel.R.S Medical College, College of Nursing, Avadi, Chennai, is edited for Tamil Language appropriateness by T. Selvarani

Name : ஜ. செல்வராணி

Signature :

ஜ. செல்வராணி, M.A., B.Ed.,
பட்டதாரி தமிழாசிரியை
சையத் முர்துஸா மேல்நிலைப்பள்ளி
திருச்சி-1



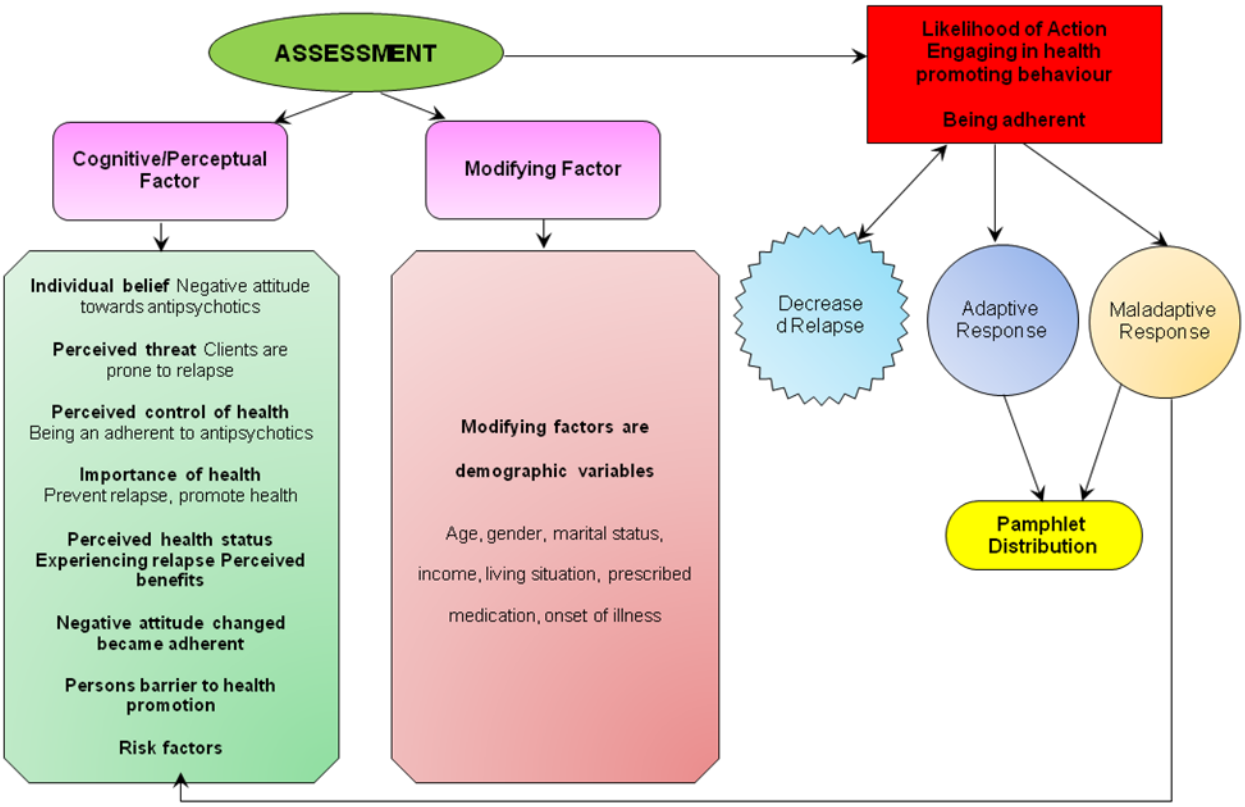


FIG.1: CONCEPTUAL FRAMEWORK BASED ON PENDER'S HEALTH PROMOTION MODEL(1987)

(ii) ஏதிர்மறையான அறிகுறிகள்

- முகபாவனையற்ற நிலை
- குறைவாக செயல்படுகிற அல்லது தொடர்ந்து செயலாற்ற இயலாத நிலை
- குறைவான வார்த்தைகள் அடங்கிய பேச்சு மிக நீண்ட நேரத்திற்கு பிறகு பதிலளிப்பது.
- குறைவான பொருள் கொண்ட பேச்சுகள்
- தன் சுத்தம் பேணாதல்
- ஒர இடத்தில் அதிக நேரம் அமர்வது.
- பொழுதுபோக்கு போன்ற அல்லது பிறருடன் தொடர்பு கொள்ளும் எந்த செயல் பாட்டிலும் பங்கெடுக்காமல் இருப்பது.
- பாதிக்கப்பட்டவாகள், நண்பர்களுடன் உறவு கொள்ளாமல் தனியாக இருந்தே பொழுதை செலவு செய்வது.

5. சிகிச்சை முறைகள்

- மருந்துகள் மூலம் சிகிச்சை பெறுதல்

  (மனநோய் மாற்று மருந்து)
- மின் வலிப்பு சிகிச்சை முறை
- மனோதத்துவ சிகிச்சை முறை
- குழு சிகிச்சை முறை

  (இச்சிகிச்சையானது குழுவில்

  உள்ளவருடன் பாதிக்கப்பட்டவர்

  தொடர்பு கொண்டு தனது சமுதாய உறவு

  நிலையை உயர்த்த வழிவகுக்கும்).

- அறிவு சார்ந்த அல்லது மன ஒருமுகப்படுத்துதல், கவனித்தல் சிந்தனை எண்ணம் சார்ந்த பயிற்சி
- குடும்ப சிகிச்சை முறை (குடும்பத்துடன் இருந்து சிகிச்சை பெறுதல்)
- சமுதாய செயல்திறன் பயிற்சி
- தொழில் பயிற்சி
- நடத்தை (செயல்பாடுகள்) சார்ந்த பயிற்சி அல்லது தொழில் நுட்பம் சார்ந்த பயிற்சி
- மனநல மற்றும் சமுதாய மறுவாழ்வு சிகிச்சை முறை.

6. சேவைமையங்கள்

- அரசு மனநல மருத்துவனை (ஐ.எம்.எச்), அயனாவரம், சென்னை
- ஸ்கார்ப் மனச்சிதைவு நோய் ஆராய்ச்சி மையம், அண்ணா நகர், சென்னை
- ஜார்ஜ் நர்சிங் ஹோம், கெல்லிஸ் ரோடு, சென்னை.
- ஆஷியானா மனநல மருத்துவமனை, புளூ ஸ்டார் (அண்ணா நகர்) சென்னை
- பெர்னான்டஸ் மனசிதைவு நோயாளர் இல்லம், குரோம்பேட்டை, சென்னை
- பேனியன் மனநல காப்பகம், முகப்பேர், சென்னை
- கிறிஸ்துவ மருத்தவ கல்லூரி மருத்துவமனை, பாகாயம், வேலூர்
- அரசு மனநல மருத்துவமனை, மதுரை.

மனசிதைவு நோய்

Schizophrenic

மனச்சிதைவு நோய்

1. வரையறை

மனச்சிதைவு நோய் என்பது அடிப்படையான குறிப்பிட்டு சொல்லும் வகையில் சிந்தனை (கருத்துக்கள்), உணர்தல் மற்றும் செயல்பாடுகளில் (நடத்தை) ஏற்படும் சீர்குலைவுகள், உணர்வுகளை வெளிப்படுத்தாத செயல்கள் மற்றும் தனிப்பட்ட நெருக்கமான சிந்தனைகள், உணர்வுகள், செயல்பாடுகள் போன்றவற்றை பிறருடன் பகிர்ந்து கொள்வது போலவும், மனக்கிலேசங்கள் தோன்றுவதும், பாதிக்கப்பட்டவர் மீது இயற்கைக்கு மீறிய சக்திகள் செயல்பட்டு அச்சமூட்டும் நடவடிக்கைகில் இறங்குவதாக இருக்கும்.

2. நிகழ்வுகள்

- ஒவ்வொரு சமுதாயத்திலும் ஆயிரத்தில் ஒருவர் மனச்சிதைவு நோயினால் பாதிக்கப்படுகிறார்கள்.
- ஆண், பெண் இருபாலரும் சமவகையில் பாதிக்கப்படுகிறார்கள்
- உச்சக்கட்ட வயதாக 16லிருந்து 35 வரை உள்ள ஆண், பெண் இருபாலரும் பாதிப்புக்குள்ளாகிறார்கள்.

3. காரணிகள்

(i) பரம்பரை காரணிகள்

- பெற்றோரில் யாராவது ஒருவர் பாதிக்கப்படுவதால்.
- சொந்தத்தில் (இரத்த உறவு) திருமணமானவர்கள்

(ii) நரம்பு கடத்திகளில் ஏற்படும் தாக்கம்

- நரம்பு செயல்பாடுகளுக்கு தேவையான நரம்பு கடத்திகளின் (டோபமைன், ஸிரோடோனின்) அளவு அதிகமாதல்.

(iii) நரம்பு வளர்ச்சிக் காரணிகள்

கர்பக்காலத்தில் (குறிப்பாக இரண்டு மற்றும் மூன்று மாதத்தில்) வைரஸ்

- வைரஸ் தொற்று கிருமியினால் பாதிக்கப்படுதல்

(iv) மூளை உளவியல் காரணிகள்

- மூலையில் அடிபடுவதாலோ அல்லது காயங்களினாலோ மூளையில் ஏற்படும் பாதிப்பு, விஷம் குடித்தல்

(v) குடும்பக் காரணிகள்

- பிரிந்த குடும்பம் பெற்றோர் பிள்ளைகள் மீது பழிச்சொல் கூறுவது
- பெற்றோர், குழந்தைக்கிடையே உள்ள பிரிவு
- பெற்றோரினால் கைவிடப்பட்ட குழந்தைகள்
- மிக அதிக பாதுகாப்பு அளித்தல்

(vi) சூழ்நிலை காரணிகள்

- மன அழுத்ததை உண்டாக்கும் சூழ்நிலைகள்
- தர்ம சங்கடமான மறக்க முடியாத அனுபவங்கள்

(vii) மனரீதியான காரணிகள்

- தொடர்ந்த அக மனதில் ஏற்படும் முரண்பாடு.
- குறைவான அறிவாற்றல் திறன்.
- நெருக்கடியான, அதிலிருந்து மீள முடியாத சூழ்நிலை அனுபவங்கள்.

(viii) சமுதாயக் காரணிகள்

- சமுதாயத்திலிருந்து தனித்திருத்தல்
- சமுதாயத்தில் தாழ்ந்த நிலை

4. அறிகுறிகள்

(i) நேர்மறையான அறிகுறிகள்

- மாயத்தோற்றம்
- தவறான நம்பிக்கை பிரமையான மனத்தோற்றம்
- தனக்கு தானே சிரித்து கொள்ளுதல்
- தனக்கு தானே பேசுதல்
- தொடர் தூக்கமின்மை
- சிந்தனையில் அல்லது எண்ணங்களில் ஏற்படும் சீர்குலைவு
- ஒவ்வாத, புரிந்து கொள்ள முடியாத அச்சமூட்டும் நடவடிக்கைகள்.